State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital

31. Date filed (Month, Day, Year)

JAN 25 2011

32. Re

KATHERINE

-32. Registrar's Signature

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CATON

ORIGINAL

BALTIMORE

AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #8 Per INF G933 11/01/2012 JH
State of Maryland / Department of Health and Mental Hygiene | 01502 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 9:10 A Ruth Marie January Seta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number 6. Sex 8. Date of Birth 1923 (Month, Day, Year) 3-19-2011 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts **Funeral** 1 🗆 M 2 🗶 F Months Min Days Hours 023-14-2480 Yrs Director Usual Residence of Decedent show or 28a-f shov notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Baltimore Maryland Timonium ō 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 12040 Tralee Road 21093 U.S.A. within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give 1943–1947
Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", Completed 3 W Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) State Assessment and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 <u>Michael</u> Mamie Clancy <u>Kiernan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traunone. 511 Harbor Drive <u>Carolyn B. Cohee</u> Annapolis, Maryland 21403 Daughter Baltimore, 20b. Place of Disposition (Name of Dulaney Cametery Cremator) or other place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 1-27-2011 Timonium Maryland Sign of Fpneral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 2011 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JANUARY 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 24 hours after death.
Funeral Director; After this leted filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) reus CRNA 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 211 JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 Registrar DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State

Registrar

6701 N.

CW

32. Registrar's Signature

57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVES

31. Date filed (Month, Day, Year)

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	01504	
	3. Time of Death 6:07 P M	
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hp int	lace (State or Foreign Ylvania	
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10	0d. Inside City Limits	
	1 🔀 Yes 2 🗌 No	
uni	try?	
ica e, e	an Indian, tc.	
it	e	

Physic Me Exar Funer Direct permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

h siciai Medic Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760

	-	For State Registrar		State of Ma	ai yiai i	•	rtificate of l	Death		Reg. No.			
Physicia Medic		Decedent's Name (First, Middle, Last) Wayne					Satterfield, Jr. 2. Date of Death January 17,			Day	Year	3. Time of Death 6:07 P M	
Examine		4a. Facility Name (if not in Glen Burnie		street and number) Rehabilitat	ion C	enter	4b. City, Town, o	r Location of Death Burnie		4c. Coun	ty of Death Arunde	21	
Funeral Director		5. Social Security Number 726-09-9466 6. Sex 1 □ M № 2 □ F 7. Age (In yrs. last birthday) Yrs.				If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birt (Month, Day April 21	(Year)		place (State or Foreign bylvania		
28a-f show otified at	Director	Maryland Maryland	. County	/A	10c. City	, Town or Lo	Ba	altimore				0d. Inside City Limits 1 🔀 Yes 2 □ No	
s 23a or nust be n	Funeral D	10e. Street and Number	1222 Wi11	Liam Street			10f. Zip Code	21230		10g. Citizen o	f What Coun ISA	try?	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u> </u> &	11. Marital Status 1 ☒ Never Married 2 3 ☐ Widowed 4 ☐ I		12. Was Decedent E Armed Forces? 1 Ves 2 1 N If Yes, Give Year or Dates, K			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, e fy: Whit	etc.	
jene. er than "nat the Medica	Completed	(Specify only highest grade completed) (Give				kind of work done during most of working				Kind of Business Industry			
dental Hyg irked othe tic event,	To Be	17. Father's Name (First, i		ayne Satterf	ield,	Sr.	.,-	18. Mother's Nam Dorothy	e (First, Middle, Edna Foo		me)		
ealth and Ν n 27 is ma er trauma		19a. Informant's Name/F		rpe, Print) (Sist	er)			and Number or Rura Street, Balt				Code)	
ment of He ant: If iten ury or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cr 4 □ Donation 5 □	emation 3 🗆	Removal from State	20b. Pl.	ace of Disp emetery, cre ar Hill	osition (Name of matory or other place Cenetery	ce) 1/21/	Date 2011	20c. Location	-		
Departi Import any inj once,		21. Signature of Funeral	Service Licens	⇔ Kevin E Ec	ker	2	2. Name and Addre	ss of Facility Mo t Avenue,	:Cully—Pol Baltimore			Home, P.A. 1230	
/sician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A CUTE MYOCARDIAL INTRODO Due to (or as a consequence of):											
aminer	er	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of): Due to (or as a consequence of):											
	Examiner	if any, leading to immedi cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	' S	c. ATR Due to (or as a	A L conseque	ence of):	BRILLA	TION			-		
physicia s the bun	Medical			d. DIAP	Fli	Es.	MECL	itus	TYDE	- 11			
within 24 hours arter death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	€ 1	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iaiii	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	☐ Ectopic pregnan☐ Other (specify) _	су			Date of delive Month	ary Day Year	
n signed b ıld be deta	ρ	Part II. Other significant		underlying cause gi		tobacco use contribute to the cause of death? Yes 2 1 No 3 Probably 4 Unknown							
cate has bee page 2 shou	Completed	SIP CANCER COLON							autop perfo	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No			
s certific director,		25. Was case referred to examiner? 1 Yes 2 No	1.9	Hospital:	nt 2 🗆 f	EB/Outpatie	26. P	lace of Death (Chec					
ath. r: After thi		27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending Investigation	28a. Date of injury (Month, Day,	у :	28b. Time o injury	f 28c. Injur	y at	28d. Describe h				
s after de	Certificate	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injur building, etc.			reet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,	
in 24 hour he Funera ipleted fille	Medical	(Check 2 D	ledical Exami	sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination	and/or inves	stigation, in my opini	on, death occurred a	t the time, date a	nd place, and o	lue to the cau	use(s) and manner stated.	
To the		29b. Signature and title o	t bertifier	a factor	164	106	29c. Licens	D 1842	6	29d. Date sign	ned (Month, L	Day, Year)	
	<	30. Name and address of	-	linahua M.D.	372	1 Doto	Stroot S	urite 6. Balt	timore Ma	arvland	21225		
State Registra		31. Date filed (Month, Day JAN 2 5	y, Year)	32. Registral	r's Signatu	ure CAR	d	or of Reli	Lande Cy I E				
		- NO	Sea left 7 8	//		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 20° 201^{Year} 4:46 RICHARD THOMAS STALEY Рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Blue Point Nursing Home & Rehabilitation Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 1 1 M 2 □ F Months Days Hours Min. Juneth 224", Y1935 Contro 75 139-28-0157 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland N/A 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 600 Light Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Bridge Construction life. DO NOT use retired) Elementary/Seconday (0-12) Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Mary Richard Martin Staley 19a. Informant's Name/Relationship (Type, Print)
Robert Lee Lednum (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 South Charter Road, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 21, 2011 Glen Burnie, Maryland 21. Signature of Funer Sprice to ensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician/ Medical Examiner

attending p

page 2 should

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Physician/

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at angles.

Baltimore, Maryland 21215-0036

Medical

10a. State

Director

Funeral

Completed by

Be

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Physician/Medical Exami Medical Certificate: To Be Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	Lung Cucurone		Sns and Death					
	Sequentially list conditions, 5 5.	Due to (or as a cons. quence of):							
	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):							
-	resulting in death) Last	Due to (or as a consequence of):							
January III	F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of death 1								
, fa 200	Part II. Other significant conditions conf	tributing to death but not resulting in the underlying cause given in Part I.		contribute to the cause of death? No 3 Probably 4 nknown					
2			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
2	25. Was case referred to medical examiner?	26. Place of Death (Ci	heck only one)						
2	T Yes 2 I No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing	g Home 5 Residence 6 R	Other (Specify)					
	27. Mann of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28b. Time of work? M 1 Yes 2 No	28d. Describe how injury of	ccurred					
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	lumber or Rural Route Number,						
5	(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place pr: On the basis of examination and/or investigation, in my opinion, death occurrence.	ed at the time, date and place, ar	nd due to the cause(s) and manner state					

00043375

29d. Date signed Month, Day, Year)

2011

State

Registrar

31. Date filed (Month, Day,

JAN 25

Year,

person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Sinature

			Pleas	e Type or Pri					_	0.0	jible.	1506
			For State Registrar	State of M	laryland	•	tment of F ficate of D	lealth and N Death		giene_ U Reg. No.		000
S	Physicia	an/	Decedent's Name (First, Middle, L	ne (First, Middle, Last) 2. Date of De							Voor	Time of Death
Physician/ Medical Examiner SINAI HOSPITAL OF BALTIMORE Month Day Year Sear Search of Death And 13 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE									73 a	20/1	5:25 AM	
									NIF	4		
10	Funeral Director			Sex 7. Ag	e (In yrs. last		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th Y Year) 7, 1957	9. Birthplace Country)	(State or Foreign
5	now at	Ē	Usual Residence of Decedent 10a. State 10b. County	t	10c. City. T	own or Locat	ion		TOPIC T	1, 101	10d li	nside City Limits
2	Marylar 28a-f st etified	recto		IA	B	. 1	more	_				1 D Xes 2 □ No
127	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number 5117 Liber	الملا الم	ahts	-	10f. Zip Code	207		10g. Citizen of	What Country?	
1/6	items ?	Fune	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. Was	Decedent of His	spanic Origin? (Sp	ecify Yes or No-		e - American In	dían,
)036	after I", ol xami	by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 If Yes, Give Year or Dates.	M 6		Yes 2 1 M6	n, Mexican, Puerto Specify:	Rican, etc.)	Specify	BQ	ck
75-6	within 72 hours giene. Ier than "natura t, the Medical E	Completed	15. Decedent's (Specify only highest g	grade completed)		(Give kind	t's Usual Occupa d of work done d IOT use retired)	ation uring most of work	ing	16b. Kind of B	usiness Industr	у
212	led within Hygiene. other tha ent, the A	0	Elementary/Seconday (0-12)	College (1-4 or 5	0+)	. 1	rsing		ant.	Heal	theau	عــــــ
vou land	be filed ental Hy rked oth ic event	To B	17. Father's Name (First, Middle, Last		DWD	es		18. Mother's Nam	ne (First, Middle,	Maiden Surname		
Patient Known 45 Baltimore, Maryland 21215-0036	€ F S D		19a Informant's Name/Relationship	(Type, Print)			Address (Street a	nd Number or Run		r, City or Town, S		21207
re, r	of Health of Fitem 27 if item 27 ir		KOSOL IOWN 20a. Method of Disposition			e of Dispositi		<u> </u>	ghts F	20c. Location	- City or Town, S	State
977/g	Page nent int: 1		1 N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)			ory or other place	12	12011	Ball	imore,	MD
Balt	permit. Page Department Important: any injury o		21. Signature of Funeral Service Lice	0/2/11	1 1	22. N	ame and Addres	s of Facility	evalote	Func	Balto.	Home MD 21207
		П	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each line	the death. De.	o not enter the	ne mode of dying	, such as cardiac	2011		App	proximate rval Between
F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)			ca 6	Sio yo	sculor	Disecce	0		set and Death
The state of the s	Examiner	L	Sequentially list conditions,	b — Due to for as a	a consequen	ce ot):						
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a consequen	ce of):						
	e executed tian and urial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequen	ce of):						
209	cate be physic sthe bi	edica		d								
× 68	h certifi tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/nths?	23c. If yes, outcome	2 Fetal de	eath 3 🗌 E	ctopic pregnancy	,		- 1	te of delivery	=
. Bo	he deat y the at ched fo	Physician/Medical	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of deat	th 5 □ O	ther (specify)			Мо	onth Day	Year
O. :	is that tigned b		Part II. Other significant conditions	contributing to death be	ut not resultir	ng in the unde	erlying cause give	en in Part I.		bacco use contr		
ords	require been si should	Completed by							1 📙 `			4 Unknown
Reco	The law ate has bage 2	omo							autop perfo	rmed?	orior to complet death? 1 Yes 2	tion of cause of
ta	ician: certifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:			Other	ce of Death (Checi	k only one)	•		
of V	y Phys er this eral dir	e: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie	ry 28	Outpatient : b. Time of	28c. Injury	4 ☐ Nursing Ho		lence 6 Othe		
ion	tending leath. :or: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigatic 3 Suicide 6 Could not	bo				yes 2 □ No				
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	al Cert	4 Homicide determined	building, etc	:. (Specify)				City or Tow			e Number,
=	e Hosp 124 hou e Funel eleted fil	Medical	(Check Z L Medical Exam	ysician: To the best of a niner: On the basis of ex rse Practioner: To the b	xamination an	d/or investigat	ion, in my opinior	 death occurred at 	t the time, date a	nd place, and due	e to the cause(s)	and manner stated.
	vithir To th		29b. Signature and title of certifier				29c. License	number		29d. Date signed	(Month Day Y	(ear)
	6		30. Name and address of person who	completed cause of de	eath (Item 22)	a) (Type Print	03	6353		6111.	7/20	((
	D V		Don Bouse	(Z Y ()	401120	B=189	- Jo-4 A	6353 Ed P3	- Stina	A Kil	212	5
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Registra	s's Signature	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Terry Lyle Taylor, Sr. January 2011 10:18 Pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medicial Center Bel Air Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye Days 216-32-6749 1 X M 2 🗆 75 Hours Year 1936 Bay City. Director Jan. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at **Funeral Director** MD Baltimore Baltimore 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3203 Honeysuckle Lane 21220 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2X Married Specify. White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Frame Rite Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Taylor Doris Evelyn Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3203 Honeysuckle Lane, Baltimore, MD 21220 Mary Taylor/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Memorial Park Parkville, MD 27, 2011 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final ISCHEMIC HEART DISEAS EVERE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical MOCOLOHUSG LANIOR 19 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Dav Year Yes 2 No 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hertensian 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been si funeral director, page 2 should? is Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 1 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🔲 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
M Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a Attendino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S.N AIR M.D., 602. ATWOOD Rd. BELAIR. MD 21014. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ :35AM anuarı William Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** TOWSON ITIMORE enter 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Davs Hours Min (Month, Day, Year) Maryland **Director** 217-16-5655 88 Usual Residence of Decedent show 10a. State 10b County 10c. City. Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No **Baltimore Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 8820 Walther Blvd. 3621 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give 1943 – 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. "natural", Specify Completed 3 ¥ Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Electricial Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Esther Rausch Samue1 Tavlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Ailsa Ave. Baltimore, Maryland Mark Taylor Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-25-2011 Towson Maryland Hilltop Service Corp. ture of Junexal Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 21204 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner If any leading to immediat cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy After this certificate has been signed by the atter funeral director, page 2 should be detached for a in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X** No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 💢 Natural 5 Pending 24 hours after death. e Funeral Director: Aft bleted filled in by the fur Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) Signature and title of certifier . License number 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month APY 2011 2.36A M Mildred Tant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Deatl AMME ARUNDE WASHINGTON MEDILAL CENT GLEH BURNIE Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. Sept. 30,1923 87 Maryland Director 217-12-3665 Usual Residence of Decedent Show 10a. State 10b. County 10d. Inside City Limits with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 X No Anne Arundel **Pasadena** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1748 Bayside Beach Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than * Elementary/Seconday (0-12) College (1-4 or 5+) N/A Foster Parent & Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Bloss Minnie Wvant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Tant (Son) Renfro Court Glen Burnie Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date VIII. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cem 01/21/2011 Brooklyn Park, MD 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Juneral Service Licenses Mountain 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ NB -UMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): YASCULAR REBRU BUDBHT Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available 24a. Was an autopsy perform prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has Yes 2 after death.

Director: After this certificat funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🗹 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one 29b. Signature and title of certifier License number 29d. Date signed (Month. Dav. Year) 2011 45146 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie Ospital 18BA1 20161 1+ 50L 82. Registrar's Signature State Registrar 2

11-00430 **Brett Vaitukaitis**

Physician/ Medical Examiner

> **Funeral** Director

Director

by Funeral

To Be Completed

Please Tv	pe or Print in	Black Ind	elible l	nk. Ens	ure A	II Copie	s Are Le	gible.	11 01	510
- For State	ate of Maryla	na / Depan	ment of	1100101	and M	lental Hy	3.5	eg. No.		OT
Registrar 1. Decedent's Name (First, Midd	lle,Last)						2. Date of Dea	ith	3. Time of I	
Brett		Vait	ukait	is			Month January 1	5, 2011	1028 h	ırs
4a. Facility Name (if not institution Rear of 55 Market Plan		mber)		4b. City, Tow Baltimo		tion of Death		4c. County of	f Death	
5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1	Year If	Under 24Hrs.	8. Date of Bi	rth (MM/DD/YYYY)	9. Birthplace (Stat Foreign	e or
218-21-1416	1XM 2F	23	Yrs		Days F	lours Min.	October	15, 1987	Country) Mar	ryland
Usual Residence of Decedent 10a. State 10b. County		10c. City. To	own or Locat	tion					10d. Inside	City Limits
	imore		Esse	x						2 X No
10e. Street and Number 10 Old Maple (Court			10f. Zip Co	1221			10g. Citizen of Wha	at Country?	
11. Marital Status 1 X Never Married 2 N	12. Was Dece Armed Fo	edent Ever in U.S. erces?	13. Wa	as Decedent of Yes, specify C	of Hispanio Suban, M es	c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	White,		3lack,
3 Widowed 4 Di	vorced If Yes, Give Year		1	Yes 2X	No spe	ecify:		Specify:	White	
15. Decedent's Education (Spe		e completed) 1	6a. Decede	nt's Usual Oc	cupation (Give kind of v	vork done	16b. Kind of Bus	siness/Industry	
Elementary/Secondary (0-12)) College (1-	-4 or 5+)		es Per	_	NOT use retir		Electro	onics	
17. Father's Name (First, Middle								Maiden Surname)		
Robert G. Vait	cukaitis					_	_	chowicz		
9a. Informant's Name/Relation Georgina Vaitu		other						mber, City or Town Jaryland		
20a. Method of Disposition 1 Burial 2 X Crematic		Ctota Cre	ematory or o	sition (Name ther place) Cremat		اما	nuary , 2011		city or Town, State	
4 Donation 5 Other S 21 Signature of Funeral Service	e Licensee	ly	22 Cc 71	Name and Ad nnelly 10 Sol	dress of F Func lers	eral He Point	ome Of Road,	Dundalk, Dundalk,	P.A. Md. 21222	2
23a. Fart I. Enter the disease, o		aused the death. [o not enter	the mode of o	lying, such	as cardiac o	or respiratory ar	rest, shock, or hea	art Approxim	nate Interval
failure. List only one bus Immediate Cause (Final diseas or condition resulting in death)	e a Mixed I	onsequence of):		ion(Me	thad	one an	d Clona	zepam)		eath
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):								
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	consequence of):			_					
X UNPENDED	d AMENDED	23a,I,II _I	erME.	G912,2	/9/20	011,WS	. 27 – 28a–	E		
IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 23c. If yes, o	outcome of pregna irth ant at time of deal	ancy 2 F	etal death Other (S <i>pecif</i>)	3E	ctopic pregna		23d. Date of Month	delivery Day	Year
Part II. Other significant cond	itions contributing to	death but not res	ulting in the	underlying ca	ause given	in Part I.	23e. Did	tobacco use contri	bute to the cause o	_
Cocaine Use							1Y	es 2 No 3	Probably 4	Unknown
								opsy p	Vere autopsy findin prior to completion of leath?	

Physician √Medical **±**xaminer

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

I Examiner	cause. Enter Underlying Cause	e to (or as a consequence of):		
Physician/Medical		AMENDED #23a,I,IIperME 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic preg	23d. Date of delivery
Completed by Ph	Part II. Other significant conditions of Cocaine Use	ontributing to death but not resulting in t		23e. Did tobacco use contribute to the cau 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes
Be	25. Was case referred to medical examiner? Hos	spital: 1 Inpatient 2 ER/Outpat	26 Place of Death (Checkient 3 DOA Other Nurs	k only one) sing Home 5 Residence 6 🗹 Other: Scene
Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At home, farm,	:25am 1 Yes 2 X No	unknown 28f. Location (Street and Number or Rural Rou or Town, State)Rear 55 Mark Baltimore, MD
Medical C	one) 2 Medical Examiner: 0	n: To the best of my knowledge, death of the basis of examination and/or investing manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurred 29c. License number	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause 29d. Date signed (Month, Da)

O Aidt Investigation I I I I I I I I I I I I I I I I I I I											
28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f Location (Street and Number or Rural Route Number, City or Town, State)Rear 55 Market Place									
3 Suicide Could not be determined (Specify)Local Street		Baltimore, MD									
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
and manner stated. 29b. Storature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
Column 1	O.C.M.E.	January 16, 2011									
30. Name and address of person who completed cause of death (Item 23a)											

900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

32. Registrar's Signature filed (Month, Day, Year) Back

Zabiullah Ali, M.D.

Assistant Medical Examiner

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\stackrel{ extstyle }{=} {}^{ extstyle \cup}$ For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ 1126 AM Wilkerson anuan John Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital NA Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Binne. Country VA Funeral Months 0 2-27-39 **Director** 219-26-7636 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD NA Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21218 1620 East 30th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mass & Company Concrete Finisher 10th Grade Be 18. Mother's Name (First, Middle, Maiden Surname)
Viroinia Smith 17. Father's Name (First, Middle, Last) မ Virginia Wilkerson, Sr. John 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 East 30th Street Baltimore, MD 21218 Patricia A. Wilkerson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lng Mem. Pk. 1 X Burial 2 Cremation 3 Removal from State 01-29-11 King Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A 638 N. Street Baltimore, MD 21217 Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Obstructive disease or condition resulting in death) horic NCS Medical Due to (or as a consequence of): Examiner ungest Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant a g Unknown Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, 1 🗌 Yes 2 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🔀 Naturai 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A: death. 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 20, 2011 20063657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. reia A. Watkins, m.D. 200 East 33 12 St., Ste. 136 Baltimare, MO 21218 31. Date filed (Month, Day, Year) State JAN 25

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{ay} 20 F Joseph Allen Wentz 7:18 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Carroll Westminster 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 ■ M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months 8-1-1969 41 215-11-6290 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Carroll Westminster 1 🗌 Yes 2 🎦 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1403 Old Westminster Rd. 21157 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Never Married 2 Married ۾ Maryland 21215-0036 hours after SpecifyWhite 1 🗆 Yes 2 🔼 No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Server Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avera-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Henry Wentz Joyce Dorsey Wentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Barrett-sister P.O. Box 915695, Longwood, FL 32791 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parkwood Cem. 1-24-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be e. 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown To the Hospital or Attending Proystoran, now annual within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the ε completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus Diabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/2/1/11 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 MALMOUD 19, Ridge Road 31. Date filed (Month, Day, Year)

JAN 2 5 2011 State Registrar

11-00647 Ronald Keith Wilson

State of Maryland / Department of Health and Mental Hygiene	0151	
State of Maryland / Department of Health and Mental Hygiene	0101	

		1- For State Certificate Registrar	of Death	Reg.		
Physicia	ın/	1. Decedent's Name (First, Middle,Last)			ay Year	3. Time of Death 0536 hrs
edical Exami		Ronald K. Wilson	Lucia Tanaharin di Bad	January 24,	2011 4c. County of Death	0530 ms
		4a. Facility Name (if not institution, give street and number) NB 702 and I- 695	4b. City, Town, or Location of Deat Essex		Baltimore Coul	•
Funeral Director		5. Social Security Number 2 1 2 - 6 0 - 9 8 2 3	If Under 1 Year If Under 24Hr Months Days Hours Min		MM/DD/YYYY) 9. Birth 1951 Foreign Cou	nplace (State or nntry) NC
ă.	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
e Maryland or 28a-f show any fied at once.	jo	MD Baltimore Ess	ex	140-	. Citizen of What Coun	1 Yes 2 X No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	1906 Middleborough Road	10f. Zip Code 21221	109	USA	uyr
P 5 E	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puert Yes 2 X No specify:		14. Race - Americ White, etc. Specify:	an Indian, Black, hite
urs aft tural"	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of		6b. Kind of Business/Ir	ndustry
21215-0036 uld be filed within 72 hours after Mental Hygeine. marked other than "natural", c event, the Medical Examiner.	Completed		g most of working life. DO NOT use re Leral Contracto		Bar-Lin	1
21215-0036 build be filed within 7 Mental Hygiene, marked other than it event, the Medica		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
Z 2 4 4 5	o Be	William E. Wilson 19a Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or	Rural Route Number		Zip Code)
MD 21 d 2 should b lth and Mer n 27 is mar		Linda Wilson /wife 19	06 Middleborou	ıgh Road	Balto. M	ID 21221
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Removal from State Bayvie	position (Name of cemetery, other place) W Crematory 1/		Baltimor	
Baltin permit. P Departme Importan injury or	H	4 Donation 5 Other Specify: 21. Sign ture Funeral Service Licens 2	2. Name and Address of Facility 3	300 Mace	Ave. Bal	to. MD
E Pos m	- 0	23a. Part I. Enter the disease, or complications that caused the death. Do not ent	Connelly Fun	eral Ho	me of Ess	ex 21221 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	of the mode of dying, such as cardiac	or respiratory arres	r, snook, or near	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
recuted and transit		events resulting in death) Last Due to (or as a consequence of): d.				
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Box 68760, death certificate be executed re attending physician and of for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending I ed for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
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tal Recian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check		, no lo	•
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on of ending Pl zath. or: After the funeral	tion: 1	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury FOUND: 5 Dending Investigation Jan 24, 2011 28b. Time FOUND: Jan 24, 2011 28b. Time FOUND: Jan 24, 2011	1 Yes 2 ✔ No	28d. Describe ho Subject drive	w injury occurred r single vehicle co	ollision
Division tal or Attendius after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highw		28f. Location (Str or Town, Sta NB 702 and I-9	eet and Number or Ru te) 5, Essex, MD	ral Route Number, City
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours and the the Attending Physician: The law requires that the To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of the control one) 2 Medical Examiner: On the basis of examination and/or investigation.	courred at the time, date and place, ar igation, in my opinion, death occurred	nd due to the cause d at the time, date ar	(s) and manner as state and place, and due to the	ed. e cause(s)
To with	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Mh. Brownell Me	O.C.M.E.		January 24, 2011	
		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900) W. Baltimore Street, Baltim	ore, MD 21223		
	tate					
Regis		31. Date filed (Month, Day, Year) JAN 2 5 2011 Senue: 32. Registrar's Signature				

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		For	State of Maryla		nt of Health and	Mental Hygie	ene2	01514
	٦	State Registrar		Certifica	te of Death	Reg	g. No.	
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Medica Examine	al -	4a. Eacility Name (if not institution, gi			y, Town, or Location of Deatl	h Jan	4c. County of Death	
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Funeral Director	,	24-24-4021	Sex 7. Age (In yrs. 1 M 2 F	Month:	er 1 Year If Under 24 Hrs. s Days Hours Min.		9. Birth Cou	nplace (State or Foreign ntry)
show dat	- 1	Usual Residence of Decedent 10a. State 10b. County	100.5	ity, Town or Location			T	10d. Inside City Limits
Maryla 28a-f	irect	MD Balt	imore Ka	nda/1sto				1 🗌 Yes 2 🖳 No
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5109 Old Co	urt Road	10f. 2	## Code ### ### ############################	10	lg. Citizen of What Cou	intry?
death r items iner m	튄	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
21215-0036 within 72 hours after giene. ter than "natural", o t, the Medical Exam	ed by	3 ₩ Widowed 4 □ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes	2 No Specify:		Specify: B	acK
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or Health a fitem 27 in other tra	ſ	20a. Method of Disposition	20b.	Place of Disposition (N	ame of	Date 2	0c Location - City or	
Page Page ant: 1		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	cify)	, , . , , , , , , , , , , , , , , , , ,	WM 1-2	8-2011 1	Baltim	ore mi)
Baltimo permit. Page Department Important: I any injury o once.		21. Signate e of Funeral Service Lice	To Maria	22. Name	and Address of Facility		eene Funera	1 Services 11) 21/33
	\dashv	23a. Part 1. Enter the disease, or co	implications that caused the dea	ath. Do not enter the mo	ede of dying, such as cardiac	c or respiratory arrest		Approximate
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Medical Examiner		resulting in death)	a. Tue to (or as a consec					
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6876C certificate nding phys	Σ/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn				23d. Date of deli	very
Box e death c the atten hed for u	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of Unknown	tal death 3 Ectopi death 5 Other			Month	Day Year
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of \ng Phy ng Phy Iter this Ineral c	iei	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how		
ttendii death. tor: A	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	t be Osc Place of Injury At h	M M	1 Yes 2 No	OOF Location (Stro	et and Number or Run	al Pauta Number
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Hospi 24 hou Funer eted fill	Medical	(Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination urse Practioner: To the best of r	on and/or investigation, i	n my opinion, death occurred	at the time, date and	place, and due to the c	ause(s) and manner stated.
To the within To the comple	— г	only one) 3 ☐ Certifying No 29b. Signature and title of certifier	urse Fractioner: To the best of F		9c. License number		d Date signed (Month,	
		· Cleer	Book	<nn td="" <=""><td>D1581</td><td>0</td><td>An 23,</td><td>2011</td></nn>	D1581	0	An 23,	2011
		30. Name and address of person who	o completed cause of death (Ite	m 23a) (Type, Print)	an Blad S	uit A	210	61
State Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:44 AM Januar 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital 90 Baltimore NIA Sinai Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth Birthplace (State or Foreign **Funeral** (Month, Day, 241-52-2898 1 M 2 🗆 F Days NaTH CRONICO A Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 ☐ No Maryland Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Jounguis Uznu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Completed by Specify: Slack 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hinore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Solomen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williams-W A ac xirhara oungui) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Frank 21 ick 1 12th 12321129 160 6.0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic obstactive Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabete 1, 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: ျပ 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number M.D RES - 000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saha Surgit M.D 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Laura Lynn Wesley :00a^M Medical 201 Januar 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Baltimore Cente If Under 1 8. Date of Birth **Funeral** 9 Birthplace (State or Foreign 1 □ M 2**X** F Days Months May 25 1961 49 **Director** Yrs permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 612 Hollen Road 21212 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Art Teacher Schools 5+ 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Wesley, Jr. Helen Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Wesley/ Aunt E.77th St. Apt. 3E, New York City, NY 10075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans, Funeral or Chapel – Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral 8800 Harford Chapel & Cremation Services 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s pck, or heart failure. List only one cause on each line. Approximate Interval Between mme hate Cause (Final Onset and Death Physician/ Nisea e or condition re ting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed frin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Division of Vital Records, 2 No Completed 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 100 Other: ျ 1 Yes 1 Nation 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work' Accident 1 \square Yes 2 🗆 No Investigation within 24 hours after der To the Funeral Director completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one d title of certifier 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 Charl Day 5 32. Registrar's signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM Glennys Rae Wise 9.45 2011 01 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours Min. April Day Year 1936 522-46-7182 74 Colorado Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Medical Examiner must be notified at Director MD Baltimore Baltimore 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 United States items 23a 5302 Kenwood Avenue 13, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 6 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working Bethel Christian life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Academy Teacher 12 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo J. Ellsworth Irene B. Terhell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Wise/Daughter 5302 Kenwood Avenue, Baltimore, MD 21206 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gardens of Faith Cemetery January 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Rosedale, Maryland 28, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final SEPSIS Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OAGULOPATHY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NO STAGE RENAL DISEASE, END STAGE 2; No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PORTAL HYPERTENSION 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESIDENT MEDICAL Ben 01/221 RES DOO 2011 GCOD SAMARITAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHRUY JOSHI BALTIMORE MARYLAND 2123 LOCH PAVEN BOLVD 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:47pm mar MANUCIM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Baynew Medical Conte Baltmore . Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min Month, Bay, Year 1936 219-32-9668 Maryland **Director** 75 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a State 10d, Inside City Limits the Medical Examiner must be notified at Director 1 Tes 2 No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral or items 23a 21222 USA 8147 Kavanagh Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Dodd Elizabeth Seuberth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Winkelman, Husband 8147 Kavanagh Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 01/22/11 Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Momoi Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final mtarction Physician ocardia disease or condition resulting in death) days Medical s a consequence of: Examiner Dizeger Oronar eave Securodally list conditions if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 2 🗌 No 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manne of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and tite of certifier 29d. Date signed (Month, Day, Year) RES-000 Jan vary 20,2011 ss of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21224 4940 Eastern Avenue James Cooper State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 5:00 A™ January John Frank Walter Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 131_Wilson_Street <u>Havre de Grace</u> Harford 9. Birthplace (State or Foreign Country) Maryland 8 Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Month Day, Days Hours 1 💢 M 2 🗆 F 1943 Director 213-40-2336 68 Ian. Jsual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? Funeral **USA** 131 Wilson Street 21078 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cytech Industries Laborer Page 1 and 2 should be filed with ment of Health and Mental Hygien ant: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Walter Edith Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Helen Walter, Wife Wilson Street Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 01/24/11 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, **Th**omas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, N Signature of Funeral Service Licensee Inc. Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Division 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Pay, Year) person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Wentworth January 2011 4:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2302 Killoran Road Timonium Baltimore Social Security Number If Under 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Hours Min Month, Day, Michigan 214-16-1448 87 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 2302 Killoran Road 21093 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give 1943–1945

Year or Dates 943–1945 Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Divorced 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Chemical Elementary/Seconday (0-12) College (1-4 or 5+) the Projec<u>t Engineer</u> Manufacturing Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If them 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wentworth Marion Lowman Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Patricia M. Wentworth Wife 2302 Killoran Road Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 1-26-2011 Towson Maryland 21. Si nature o Fine al S rvic 22. Name and Address of Facility Ruck Towson DFuneral Home, Inc. Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10ma Physician/ NOW disease or condition 16 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached a \ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 1 Yes 2 No 2 **X** No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 1 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury hours after death. neral Director: Aft d filled in by the fur 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frantiener: To be best of my browledge over a continuent to the fire, date and place and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 1 Co Chipual) 91 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETTINGEY DAVID Jo h 591

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 25 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 2011 12:27 P M Physician/ Ε. Wardley Dorothy Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Morningside House of Satyr Hill Baltimore 8. Date of Birth (Month, Day, NOV 21 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Min. Davs Hours 1 □ M 2 □**X**F Months Maryland 212-14-3669 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10b County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 Ves 2X No Phoenix Baltimore MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe by Funeral USA 21131 13722 Princess Anne Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. altimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Edith Mae Rice ပ္ Russell William Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13722 Princess Anne Way Phoenix, MD. 21131 Patricia Armstrong/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-25-11 Baltimore, MD. Hollv Hill Mem Gdns 22. Name and Address of Facility Funeral Home, 21. Signature of Fun ral Service Lice see 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to ininediate cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Box 68760 attending pl for use as tl IE EEMALE: 23d. Date of delivery 23h. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached g Unknown P.O. to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed 1 🗌 Yes 2 🗆 No 2 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No 5 Residence ျှ 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Manner of Death Certificate: 24 hours after death.

Funeral Director; After leted filled in by the funer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours after

To the Funeral Direcompleted filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 We-01 0 a

Registrar

DHMH 17 Rev 7/2009

State

32. Registra

11-00491 Joseph Young Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 18, 2011 0053 hrs **Medical Examiner** Joseph Louis Young Sr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Director 1X M 2 F 03/13/1938 217-34-9212 72 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 XYes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygener
Important: If item 2; is marked other than "natural", or items 23a or 23a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. N/AMD Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 833 W. Pratt St. Apt 217 U.S.A Funeral 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Armed Forces? 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black Š 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comple East Coast sweep Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Young Margaret ဥ 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Pratt St., Constance Young (daughter) 833 Apt 217, Balto., MD21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c, Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/26/11 Baltimore, MD Mt. Zion Cem. Donation 5 Other Specify 22 Name and Address of Facility
Joseph H. Brown Jr. Funeral Home PA
2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service License DU Approximate Interval 23a. Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death a End-stage Renal Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury trial initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760, he death certificate be 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 Unknown Dementia Completed certificate has been sector, page 2 should 24a Wasan 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) To the Hospital or Atteodiog Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification 1 V Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 18, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:29 P M Barbara Joan Zanchetta 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1B Mopec Circle Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🔀 F Months Days Hours (Month, Day, Ye Baltimore, MD 220-34-5394 72 Director 1938 Nov Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 1B Mopec Circle 21236 23a United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 X Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Phelps Doris Mundey 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1B Mopec Circle, Baltimore, Maryland 21236 Larry Phelps/ Brother other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite Janu^{Date}ry Evans Funeral Air Chapel - Bel Air injury or (1 Burial 2 XCremation 3 Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) 25 201 Sig tyre of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiomuopa Ph sician/ dismse or condition ulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death ed by the a detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be der Completed by 2 No 3 Probably 4X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension autopsy performed? Yes 2 No or Attending Physician; The certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2X No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rinill umti D0064203 3011 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conter 6565 N. Charles St. Ste Medical

Registrar

State

Greader Baltimore 31. Date filed (Month, Day, Year)

JAN 25 20

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 6:12 PM Zahner 2011 Herman <u>Joseph</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Date of bi. (Month, Day, Yea Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Days Min Director <u>213-32-1372</u> Feb. 74 items 23a or 28a-f show ier must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 1108 Gypsy Lane West 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give 1956 – 1957 Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner , or Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 □ Divorced White Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natuiury or other traumatic event, the Medical jury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Wire Elementary/Seconday (0-12) College (1-4 or 5+) <u>Plant Manager</u> Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Edward</u> Robert Zahner Catherine Ε. Dotterweich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Meredith Drive Sparta, New Jersey <u>Joseph E. Zahner</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-29-2011 Maryland Towson 22. Name and Address of Facility Ruck Towson Funeral 21. Sign tur Inc. 1050 va Road York Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ABDOMINAL AORTIC ANEURYSM DISSECTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: performe 1 ☐ Yes 2 ☐ No Yes 2 X No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis 3 Certifying Nurse Practioner: e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND M.D., KHOSROW TABASSI 32. Registrar's Signature State JAN 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Franklin 2011 8:45 P. M George January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Riverdale** Prince Georges Crescent Cities Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 577-50-5610 73 Yrs Washington, D.C Director June Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Prince Georges Maryland College Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral United States 20740 6200 Westchester Park Drive; Apt.801 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black White etc. ö ģ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: B1ack Specify: 3 Widowed 4 X Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working D. C. Department of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreman/Water & Sewer Dept. Public Works 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever ٥ Woods Avert Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CodeMaryland f Health aitem 27 i 6200 Westchester Park Drive; Apt. 801; College Park, Lisa Elaine Adams (Daughter) other t Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other Jan. 12, 2011 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Signature of Funeral Septice Lices 22. Name and Address of Facility R. N. Horton Company Morticians, Dandelph. Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p for use as t IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of Old Cerebrovascular Accident 24a. Was an has autopsy performed? Yes 2 X N death? 25. Was case referred to medical of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examingation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D20079 7, 2011 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8116 Good Luck Road; Suite 300 Don H. Yablonowitz, M.D. Lanham, Maryland 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

IAN 1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1733 M ADAMS ANDIRE 2011 JUANITA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRINKE #107 HEICHTS ADDI APITOL KOKD 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 1 M 2 X F Days Hours Min. Months 7-48-6822 15 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City. Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 Yes 2 □ No HEIGHTS 00,102 10f. Zip Code 10g. Citizen of What Country? USA Funeral ADDISON 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give ģ 1 🗌 Yes 2 💆 No Specify: BLACK Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) PRIVATE Elementary/Seconday (0-12) MANAGER Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANITA မ CARTER DAVIS HDams am 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SPEINADALE. H. THOMPSON BlemansTERR DAUGHTER 4318 ELANNE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-10-2011 RIVERDAE RIVERDALE PARK CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20011 WASH, DC 814 UPSHUR STAW 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovacculas HEART DI SEASE ATHEROGLEROTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or se a consequênce of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Vunknown Month Day 5 Other (specify) Pregnant at time of death ed by the a detached for g | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Matural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 a valuation 5 y vestigation of the state of the 31. Date filed (Month, Day, Year) State JAN 1 2 2011 Registrar

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 1 1 2011

701 Randolph Rd # ZVb. ROCKVILL, MD 2085Z

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 1213 M Helen B. Arbuthnot Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 2 Hours 149-03-9571 Director 93 _1917 N_ Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director MD Carroll Westminster 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2429 Coon Club Road 21157 USA items death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after do ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 212 No Specify: Specify: white 3 ▼Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home <u>homemakeı</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Brown Lillian Beyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Arbuthnot, son 2427 Coon Club Rd., Westminster, Md. 21157 Baltimore, Department of Healmoortant: If item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/3/2011 | Hampstead, Md. injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M00741 semmer S. Main Hampstead, Md 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or 1 a consequence of): Physician/ disease or condition resulting in death) Medical Examiner WINTENSU Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examine Due t or s a consequence of) Due to (oras a consequence of): death certificate be executed and that initiated events resulting in death) Last the burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month ☐ Pregnant at time of death☐ Unknown 5 Other (specify) ed by the a g | Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my 2 Medical Examiner: On the basis of example as a Certifying Nurse Practioner: To the best of the b 29a. Certifier knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. or and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated by knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. inatio To the within 2 only one) 29b. Signature and title of certif 29c. License numbe 29d. Date signed (Month, Day, Year) 037949 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person Alexander 32. Registrar's Signature State Registrar JAN 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra MEND#17perINF, 1/7/11, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:15 a^M Elizabeth Charlotte 2011 Albanesi Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth
(Month, Day, Year)
Jun 12, 19 . Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖫 F Months Hours Min. 578-26-7454 Director 85 D.C. 1925 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 V No P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6107 10th Place 20782 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Executive Secretary Be other traumatic event, 17. Father's Name (First, Middle, Last) John Thurman Miller John Thurmon Miller permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or ----18. Mother's Name (First, Middle, Maiden Surname) ٥ Amelia Elizabeth Kunowsky 19a. Informant's Name/Relationship (Type, Print) – ${\sf Daughter}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Ann Wheatley 12901 Black Oak Drive, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1/5/11 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins 1 500 University Blvd. Funeral Home Inc. . W, Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) UNE class Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Year 5 Other (specify) Day been signed by the should be detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 2 🗌 No 1 Tes Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? No No Hospital Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending thin 24 hours after death.

the Funeral Director: Af
expleted filled in by the fu 1 Tes 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 340, TAL MAPARILIL MD 20912 KARIFITGIO CAREBLL State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 <u>2011</u> Physician/ 8:20 AM BRYANT JANUARY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CHERRY HILL NURSING HOME LAUREL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) (Month, Day, Year **Funeral** Months Days Hours Min. NORTH CAROLINA 1 M 2 DX 577-24-1528 **Director** 96 1914 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 ☐ No PRINCE GEORGE'S LAUREL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 9001 CHERRY LANE 20708 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Black, White, etc 1 Never Married 2 Married Yes 2 X No Completed by Maryland 21215-0036 1 Yes 2 X No BLACK Specify "natural", 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE PRIVATE 2+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ANDREW BRYANT DELIAH HUGHES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY SPEARS/NIECE 1405 DEANUBE COURT BOWIE, MARYLAND 20721 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 1/10/2011 SUITLAND, MARYLAND J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 pt enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CEREBROVASCULAR ACCIDENT Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami equires that the death certificate be executed and -trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Year Month Day Pregnant at time of death 9 Unknown the i 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: T e law 124 hours after death.
• Funeral Director: After this certifica e has ! autopsy performed' 1 ☐ Yes 2 🕱 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည 2 🖳 No 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title JANUARY 7, 2011 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IKECHI OKWARA M.D. 12200 ANNAPOLIS RD #316 GLENN DALE, MARYLAND 20769 32. Registrate Signature

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JÄNUARY 2011 5:50 PM JOHN WILLIAM BLATTNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. (Month, Day, Country) Fairfax 28 213-06-9749 Director Apr Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's 1X Yes 2 No Riverdale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 Riverside Drive 20737 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 K Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ DC Public Schools Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William A. Blattner Diane M. Mach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Blattner - Wife 5906 Riverside Dr., Riverdale, MD Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 1/10/2011 1 Burial 2 K Cremation 3 Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Zone disease or condition VEATS Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant
Unknown Month Pregnant at time of death 5 Other (specify) Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 XNo Yes 2 No 1 🗌 Yes **Division of Vital** Hospital or Attending Physician: completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🔲 Yes Other: 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 01/08/2011 D64823 MD PUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 Michael Eberlei 31. Date filed (Month, Day, Year, 32. Registrar's Signature State ack JAN 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BASAR 07.30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPI MONTGOMERY 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours MONTENEGRO 1 🗆 M 2 🕱 F 215-45-039 **Director** show. 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ hours after death with the Maryland Director r 28a-f s notified 1 X Yes 2 No GAITHERSBUR MONTGOMERY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o Funeral 208 BOSNIA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) CLETHING FACTORY WORKER and Mental Hygien is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ HATIDZA IBRAHIM CAUSEVIC CAUSEVIC permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BASAR SON LN. GAITHERSBURG MD. 26879 MIRSAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CI/10/2011 FREDERICK MD CEMETERY 4 Donation 5 D Other (Specify) FIRDAUS 22. Name and Address of Facility ADEN MUSL IM FUNERAL 21. Signature of Funeral Service Licensee EASY ST. WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NGESTIVE Ph_sician/ HLART disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ORO WARY Saquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 You

9 Unknown ate has been signed by the atterpage 2 should be detached for a Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 TYes To Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funel completed fil 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier sen, ms DO057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DR. #208 MD IRUONIG State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 Physician/ FLAINE BELLISON 9:57 AMPEGGY January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Jan. 27, Months Days Hours Country)
Maryland 79 215-46-4740 1931 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 😾 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9910 Tune Avenue 20872 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurateur Restaurant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lindsey L. Browning Mary 0gle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard T. Bellison - Son 9312 Second Avenue, Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Damascus Meth. Cemetery 1/15/2011 Damascus, Maryland 21. Signature of Juneral Service License 22 Name and Address of Facility Molesworth—Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1-ZUKCS NORENO Sequentially liet conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Year Pregnant at time of death page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by Status abdomina 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cor has performed this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director, After this certific, completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🔲 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Beath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Perifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29c. License number MDD65378 21701 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 400 West 7th Street, Frederick, Maryland Lacuron

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elliott M. Burroughs 2011 10:53 A.M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Callaway Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 19, 1 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 🛛 M 2 🗆 F Hours 76 212-30-4832 **Director** 1934 Maryland Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-1 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Mechanicsville St. Mary's Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ems 23a or r must be Funeral USA 20659 39924 Graves Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc à 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates marked other than "natu matic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Truck Driver Construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Mary Priscilla Hayden Henry Harvey Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Burroughs/ Son 39924 Graves Road Mechanicsville, Maryland or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State January 14, injury 4 Donation 5 Other (Specify) Charles Memorial Gardens 2011 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 Signature of Funeral Service License uchael 7 wier tard 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or a consequence of) 13 monms Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) g 🗌 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown as ar while in anticorgulant Falls 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s performe death? er this certificate haren 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA ည After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural s after death.

I Director: Afted in by the function 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined n 24 hours af le Funeral Di oleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier -10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minal M. Shah, MD 23415 Three Notch Road California, Maryland 31. Date filed (Month, Day, Year) State JAN 10

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 01 2011 George Ball January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min. (Month, Day, Year) 08/10/1945 1 XM 2 - F 65 Director 579-62-0540 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f 1 ¥ Yes 2 ☐ No Md. P.G. Capitol Heights 10g. Citizen of What Country? 10e, Street and Numbe ò 23a U.S.A. 5626B Coolidge Street 20743 of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Married 2 X Married Completed by Maryland 21215-0036 African-1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced American Year or Dates 15, Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University Park-Elementary/Seconday (0-12) College (1-4 or 5+) College Park, Md. Maintenance Worker 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosaline Griffin Louis Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other tra Lois L. Ball/Wife 5626B Coolidge Street, Capitol Hgts., Md. 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. Date 0 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA Physician/ FATAL disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** DIABETES Sequentially list conditions, Examine Due to (ur as a consequence of, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical REWAL Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 \square No 3 \square Probably 4 \nearrow Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 X No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 💹 Natural 5 Pending after death. М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check Cartifying Nurse Fractioner To the best 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD G-RIFFIN DAVIS 3001 HOSPITAL DR. 31. Date filed (Month, Day, Year)

JAN 0 6 2011

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** EDGAR F. BRIMER, JR. 8:45A M 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ESS ANNE If Under 24 Hrs. 8. C SOMERSI PRINC If Under 1 Year MANOKIN MANOR Date of Birth (Month, Day, Year) 05-16-1921 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days Min. 1 M 2 □ F Months 218-14-2434 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examinatings be restilled at 1 res 2 □ No Director Md. Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Eventual variable in once. 21853 30502 Williams Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Was December 2 In 0.5.
Armed Forces?
12 Yes 2 □ No 1942
If Yes, Give
Year or Dates: To 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) To Be Edgar F. Brimer Gertrude Evans Brimer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Johnson Brimer Wife 30502 Williams St. Princess Anne, MD. 21853 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01-06-2011 Beechwood Cemetery Princess Anne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 21853 11673 Somerset Ave., Princess Anne, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final ease or condition resulting in death) Chronic ohstructie Physician 24eax /Medical Due to (or as a consequence of): Examiner DEMENTA 2 year Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) **Hospital or Attending Physiclan:** The law requires that the death certificate be executed 24 hours after death. Syean physician and s the burial-transil ASCVD Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 92s autopsy performed 1 ☐Yes 2 ☐ No 1 ∐Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mle N 3rd 2011 0051359

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

BAIMER,

1415-S. DIVISION ST,

SALISBURY, M3 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

NATESAN

· USHA

Day,

JAN 06 2011

DR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 17. 201^{Year} Physician/ 20:50 PM <u>January</u> Delores Collier Bowe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 0872371942 1 M 2 3 Days Hours Virginia 213-40-9853 Director 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💆 No Marvland Calvert Lusby 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 20657 12918 Ottawa Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2 The þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural", Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Operator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mavis Mozelle Morris Lewis Lloyd Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12918 Ottawa Drive, Lusby, Maryland 20657 Dawn Hammons / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01-24-2011 Holly Memorial Gardens Charlottesville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Rausch Funeral Home, P.A. 20 American Lane, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ACUTE MY OCARDIAL disease or condition resulting in death) MINUTE Medical Due to (or as a consequence of) Examiner ATHERS SCIETOTIC CARDIOVASCULAR Sequentially list conditions Examine ii any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ģ OBSTRUCTIVE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an FIBRILL ATIO page 2 s autopsy performe nas ANEMIA certificate 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No hours after death. 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26358 January18, 2011

State

Registrar

John H.

31. Date filed (Month, Day, Year)

Weigel

110 Hospital Rd., Suite 310, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ Month 2011 Year 15 Jan. 1:30 PM Deborah R. Baker Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, You Months Hours Min. Year 1 M 2 X F Yrs 218-54-3620 60 **Director** Apr. MD Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Cockeysville MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10409 Greentop Road 21030 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Supplies Admin. Assistant 12 of Health and Mental Hygie f item 27 is marked other ' r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Beryl Rosier Hilda Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Baker/Husband 10409 Greentop Rd. Cockeysville, MD 21030 Baltimore, Date 20, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3X Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) New Freedom Cem. 2011 New Freedom, PA Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary El Me 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Puim ON APG Due to (or as a consequence f): EMBOLISM MINUTES disease or condition Medical resulting in death) Examiner METASTATIC PANCREATIC if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown CHRONIC FULMONARY EMBOLUS 24b. Were autopsy findings available prior to completion of cause of death? MALIGNANT ASCITES 24a Was an has page 2 autopsy performe After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the nopperson within 24 hours after death.

To the Funeral Director: After the funeral property of the fure X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature-and title of certific 29d. Date signed (Month. Day, Year) D64395 JANUARY 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH CHARLES STREET, SWITE 4105 BALTIMORE, MD 2, 204 DANIELLE DOBERMAN, MD 6701 31. Date filed (Month, Day, Year) 32. Registrar's signature State Registrar 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 15 8 per fh. 2940 6-4-13 sm State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ January Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 5. Social security Number GOOLOD. mn If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ye Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ar 1965 1 🗆 M 2 🔽 Months Director 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code ö 10e. Street and Number items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) mist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Department of Health ar Important: If item 27 is any injury or other trau ના 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9 4 Donation 5 Other (Specify) 21. Signature of June a Service License 22. Name and Address of Facility MAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami s been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 10 Path-2 00 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy 1 ☐ Yes 2 ☐ No Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 Like Other: မ 1 mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work?
1 Yes 2 No 1 Natural
2 Accident injury 5 Pending s after death. Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MDD 60611 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK ROAD LANHAM MD ASFAW M.D. 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month Year MABLE E. CRAWFORD /7/201 М 2149 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE"S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year 3/26/1917 9. Birthplace (State or Foreign Country) P.G. Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Min. 1 M 2 1 F Director 214-18-0318 93 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince George's District Heights 10f. Zip Code 10g. Citizen of What Country? Funeral 1203 Edenville Drive 20747 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wesley Colbert Hattie Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis V. Crawford / G- Son 2474 Bell Branch Road Grambrill, Maryland 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 1/14/2011 Clinton, Maryland Resurrection 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes. P.A. 5538 Marlboro Pike Forestville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATAL CARDIAC ARRHYTHMIA Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Directo (or as a consequence or) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 24 hours after death. Funeral Director: After 1 Natural 2 Accider (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of phy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIFFIN DAVIS, CHEVERLY MD. 20785 3001 HOSPITAL DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 1Day 2011 1:24P M CHARLES J CHARUHAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 7. Age (In vrs. last birthday) Feb. 15, Year) 921 Days Hours Min. 1 12 M 2 D F 89 Washington, D.C Director 578-20-9670 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Mt. Airy Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 Funeral 706 Midway Avenue USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 196
If Yes, Give 196 13. Was Decedent of Hispanic Orlgin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. white "natural" Completed 1946 Specify: 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Officer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Charuhas Angelike 19a. Informant's Name/Relationship (Type, Print) 196: Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5822- Midway Avenue, Mt. Airy, Maryland 21771 Mary Charuhas - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Frederick, Maryland Mt. Olivet Cemetery 1-10-2011 4 ☐ Donation 5 ☐ Other (Specify) . Si priture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ENA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner INFECTION TRACT To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō 5 Other (specify) Month Day Vear Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate Yes 2 No 2 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 01/04/2011 19-Um 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Regist ar's Signature State Rosera Registrar

Maryland 21215-0036 Baltimore, Box 68760 P.O. Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Clabaugh January 6, 2011° 6:27A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Northampton Manor 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 🖺 F me 1, 84 Yrs Maryland Director 218-30-8808 June Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗌 Yes 2 🏝 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 9602 Bartgis Road 21702 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. white 3 Widowed 4 Divorced Specify: Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) Il Hygiene. College (1-4 or 5+) Beautician Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H Edith Fogle Lester Utterback 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9602 Bartgis Road, Frederick, Maryland 21702 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Mike Clabaugh - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 1-10-2011 Frederick, Maryland 4 Donation 5 Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike, Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy aw has page 2 performed No Hospital or Attending Physician: The L24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No completed filled in by the funeral director, Was case referred to 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I 4x Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifie completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ Month 8 3:00 P M HENRY HALE CLOUGH, III JAN. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) **Director** 577-36-5488 88 Usual Residence of Decedent 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD MONTGOMERY SANDY SPRING 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 1614 HICKORY KNOLL ROAD 20860 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1942 Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE 1945 Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE AGENT INSURANCE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ HENRY HALE CLOUGH, II HELEN ANDERSON permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 19a. Informant's Name/Relationship (Type, Print) GERMANTOWN, CANDICE CLOUGH / DAUGHTER 11302 HARVEST MILL LA., 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 01/10/201 4 Donation 5 Dother (Specify) FREDERICK, MD 22. Name and Address of Facility .0. BOX 86 HILTON FUNERAL HOME u BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition a ACUTE RENAL FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner OBSTRUCTIVE UROPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): SEPSIS Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial CYSTITIS Physician/Medical Division of Vital Records, P.O. Box 68760 the 88 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 Yes Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 No Accident Investigation 24 hours after deatr Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0060634 JAN. 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH, BINDU MD 6001 MUNCASTER OTIVA MILL RD.. ROCKVILLE, MD 20855 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 2011 ĬŎ. 12:55 a.M Marie Scholes Crowe Helen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Solomons Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F (Month, Day, Year) 07/05/1926 Director 039-14-2150 84 Rhode Island Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Tes 2 No St. Mary's City Maryland |St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 17730 Rosecroft Road 20686 or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 - Widowed 4 - Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Retail Sales Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ည Howard Scholes Alice Dorothy Scattergood t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 68, St. Mary's City, MD <u>Walter Q. Crowe/Husband</u> or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 01/13/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, 21. Signature of Funeral Service Licenses Brinsfield M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimer's Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Year ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Atheroscerosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed? Yes 2 X No death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No 1 Tes Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 M Nursing Home 5 Residence 6 Other (Specify) this Director: After the in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hou. the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tite of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

JAN 11 2011

Charles Benner,

31. Date filed (Month, Day, Year)

D31563

20945 Great Mills Road, Lexington Park, MD

01/10/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11 = 39 PM 290 2011 ddie Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death niversize Baltimore Baltimas If Under 1 Year | If Under 24 Hrs. CV 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Days Hours Country) Director 85 235-44-0945 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No Maryland St. Mary's Charlotte Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Rd. 20622 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

X Yes 2 □ No
If Yes, Give 11. Marital Statusunknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Construction Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Mitchell/Friend 109 Woodland Rd., Indian Head, MD 20640 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem 01/12/2011 Charlotte Hall, MD 22. Name and Address of Facility 3rinsfield-Echols F. H., F.A. . Signature of Funeral Service Licensee MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Funeral Director: After this certificate has appleted filled in by the funeral director, page 2.3 autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) Natural 5 Pending injury Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimone Shin Mira 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2 ay 201 Î^{ear} Michael S. Chase, Sr. 09:44 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 XM 2 ☐ F Days Sept. 13,1961Prince Frederick Min. Hours Months **Director** 217-84-0251 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince Georges 1 😾 Yes 2 🗌 No Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6907 Kingston Dr. 20748 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Entreprenuer Private permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Noble Chase Evelyn Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6907 Kingston Dr. Temple Hills, Md. Donna Wright / Wife 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resurrection 1/11/ 2011 Clinton, Md. Sign vure of Funeral Service Lic see 22. Name and Address of Facility
Alexander, S. Pope, P.A.
5538 Mariboro Pike/ Forestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an Was an autopsy performed? page 2 s certificate this certificaral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ieral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in the property of the prope within 24 hou

To the Funer

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a nd title of certi 29c. License number 29d. Date signed (Month, Day, Year) January 4, 2011 D-41580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott A. Kelso, M.D. 7503 Surratts Rd. Clinton, Md. 20735 31. Date filed (Month, Day, Year) 32. Registræ's Signature State JAN 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mary orbet 2:00 A.M Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Princess Somerset Westover Anne 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Ye Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🜠 F Months Days Hours Min **Director** 055-22-2614 North Carolina Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. Count filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Somerset Westover 1 Yes 2 No Maryland ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral Rd Princess 11, S. A. 8982 21871 012 items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc ō à 1 Never Married 2 Married ☐ Yes Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 er than "natural", the Medical Exan 1 ☐ Yes 2 No Specify. 3 ⅓ Widowed 4 ☐ Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of the and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service 12th grade Secretar V.S. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မှ mildred Thomas Williams Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Princess Anne, Corbett -898 oid Westovenmd, 21871 grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗗 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Westover 18 111 4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Licensee Anthony E 22. Name and Address of Facility ward Warl 4. Princess Anne, and 2 1853 0639 Hamoden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ MAZIGNAN disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it my lead to the cause. Enter Underlying Cause (Disease or linjury Examiner Daw to (or as e consequence of): as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes No
9 Unknown Pregnant at time of death Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Onknown Completed Director: After this certificate has been s d in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. bescribe how injury occurred Natural
Accident
Suicide
Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc City or Town, State) ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my onlines death assured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Praction of Tathe basis of my knowledge, seath occurred at the time, date and place, and doe to the cause(s) and manner stated. Quittlying Nurse Prantianer: To the best of my knowledge. 0 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAR 0 1300 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. 14,2011 MARY ELLEN CROTHERS-STEVENSON 2:08P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15275 DEBORAH DRIVE HUGHESVILLE CHARLES Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 219-42-4450 1 🗆 M 2 🗓 F Days Hours Min 7 Manta Day 944 **Director** 66 WASH D.C. Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits MD. CHARLES HUGHESVILLE 1 🗆 Yes 2 🔀 No 10e Street and Number ò 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 15275 DEBORAH DRIVE 20637 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter 14. Race - American Indian. þ 1 Never Married 2 XMarried Black, White, etc. Yes Yes, Give Baltimore, Maryland 21215-0036 2 XVo 1 Yes 2 XNo Specify: Specify: WHITE Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than event, the N Elementary/Seconday (0-12) College (1-4 or 5+) 12 HUMAN RESOURCES MGR. U.S.GOVT. 1 Be 17. Father's Name (First, Middle, Last) id Mental F marked o 18. Mother's Name (First, Middle, Maiden Surname, 2 HAROLD AVRICK SUZANNE SHACKELFORD traumatic and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E 15275 DEBORAH DR. HUGHESVILLE, MD. 20637 Department of Health a Important: If item 27 is any injury or other trainonce. GEORGE BERT STEVENSON-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State MD TERTANS THE CEM. 1 - 24 - 11CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) of Far eral Service Licenses RAYMONDS FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and resulting in death) Last burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the attending p as IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo 5 Other (specify) Day Month Year 1 Yes 2 No ed by the a Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe 1 Yes 2 XNo Division of Vital filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident 1 Tes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie signed (Month, Day, Year) use of death (Item 23a) (Type, Print) f person who completed md. Dont. THE W 31. Date filed (Month, Day, 32. Register's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 15, [□]20<u>11</u> Carolyn Collins Medical Marie 2225 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Co. Nursing & Rehab Ctr. Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months | Days | Hours | Min. Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD 1 🗆 M 2 🖵 F Hours Director Sep 23 220-88-1813 Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location ems 23a or 28a-f sh r must be notified a 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 730 Furnace Street 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 9 1 Never Married 2 Married ğ Black, White, etc. Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates white Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Collins Elmira (Long) Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health a tem 27 is Rhonda Kalbaugh Daughte 1107 Virginia Avenue Cumberland MD 21502 t of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Department o Important: If any injury or ö 1 X Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 1/18/201 4 Donation 5 Other (Specify) LaVale MD 21. Signature of Funeral Servi 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enterthe disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy Live Birth 2 🗌 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Dav Year 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à To the Hospital or Attending Physician: The law requires twithin 24 hours after death.
To the Funeral Director: After this certificate has been sigr Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မြ Other ER/Outpatient 3 DOA 1 Inpatient 2 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manuar of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 🗆 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and Itle of certifie 29d. Date signed (Month, Day, Year) warno 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) KOBUSTIANO J. BARRÉRA STE. 302 M 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Havre de Grace, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** STEPHEN RONALD CECIL 2011 8:50 PM Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genesis HealthCare -The Pines Easton 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 1 X M 2 ☐ F 11/5/1942 MARYLAND Director 282-36-7026 68 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10h. County 10c. City. Town or Location show rotified 1 ☐ Yes 2X No Director ST. MICHAELS 28a-f MARYLAND **TALBOT** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be a 1008 RIVERVIEW TERRACE 21663 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Completed by Specify: Specify 3 Widowed 4 Divorced WHITE the Medical 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Industrant once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT / CEO **MANUFACTURING** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil ပ JOSEPH FRANKLIN CECIL JESSIE COOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tephen SARAH ANNETTE CECIL / WIFE 1008 RIVERVIEW TERRACE, ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MtD SHORE CREMATION CENTER BY 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2011 CAMBRIDGE, MD COLLEEN CURRAN-BROMWELL, P.A. 21. Signature of Funeral Service Livensee 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed DROWARS burlal-trar Due to (or as a consequence of) signed by the attending physician be detached for use as the burlal Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 LINO 2 No 1 ☐ Yes Physician: ours after death.

neral Director: After this certific, filled in by the funeral director, t Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Harsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 33336

IN D

Registrar

DHMH 17 Rev 1/2001

State

Name and address

DUTCHMAN

of person who completed cause of death (Item 23a) (Type, Print)

NP GIO 1 32. Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		1 🗌 Burial 2 4 🗌 Donation	Cremation 3 5 Other (Spe	ecify)	State	cemetery	r, cremato	ory or other pla	ce) 7 Cre	01/22 mator	72011 ium			-	
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8760 tificate being physic as the b		F FFMAI F:													
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as Medical Certificate: To Be Completed by Physician/Me	2	3b. Was decedent in the past 12 n 1 Yes 2	nonths?	1 ∐ Live Bir 4 ☐ Pregna	rth 2 ∐ Feta nt at time of c	l death		topic pregnand her (specify)	у						,
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To with		9b. Signature and the	e of certifier	1 Sun	ella	NI)		29c. License	number			29d. Da	ate signed (M	onth, Da	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of State of Maryland / Department of Certificate o		01554
	Physici Medi Exami	cal	Dorothea Mathilda Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Tow	2. Date of Death Month Day Year January 8th, 2011 //n, or Location of Death 4c. County of De	7:47 A M
400	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 You	ays Hours Min. (Month, Day, Year)	y's Birthplace (State or Foreigr Country) Yland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Maryland St. Mary's Leonardtown 10c. City, Town or Location Maryland St. Mary's Leonardtown 10c. Street and Number 10f. Zip Coc 21585 Peabody Street 2065 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) No Specify: Cocupation One during most of working red 18. Mother's Name (First, Middle, Maiden Surname) Martha D. Mueller Martha D. Mueller Teet and Number or Rural Route Number, City or Town, State, 2 10, Leonardtown, MD 20650 Mother's Name (First, Middle, Maiden Surname) Martha D. Mueller Date 20c. Location - City of Town, State, 2 20c. Location - City of Town, City of Town, City of Town, State, 2 10, Leonardtown, MD 20650	nerican Indian, iite, etc. iite si Industry er Zip Code) or Town, State Hall, MD Iome, P.A.
90	Medical Examiner the burial-transit the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Dementia		Approximate Interval Between Onset and Death Years
Vital Records, P.O. Box 68 vician: The law requires that the death certificate has been signed by the attending director, page 2 should be detached for use as one Be Completed by Physician/M	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	Month e given in Part I. 23e. Did tobacco use contribute t	Day Year	
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State Registrar

JAN 1 1 2011 DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Peter Kevin Donovan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day January 4, 2011 **Medical Examiner** Peter Kevin Donovan 0957 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death 14311 Tunnel Avenue Apt.304 Ocean City Worcester 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 220-56-8637 Country) MD 1 X M 2 F 59 11/17/1951 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shore 1 X Yes 2 No MD Worcester Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
suit: If item 27 is marked other than "natural", or items 23a or 28a-f sho Ocean City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14311 Tunnel Ave. Apt 304 21842 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2X No Yes 3 Widowed 4 X Divorced f Yes, Give Year 1 Yes 24 No specify: Specify: White <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

it: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 teacher's aide education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Merritt Peter Donovan Jacquelyn Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Donovan 538 Bay Green Dr. Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 1st State Crematory 1/8/2011 4 Donation 5 Other Specify Millsboro, DE 22. Name and Address of Facility The Burbage Funeral Home re o ral Service 108 William St. Berlin, MD 21811 he dise e, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Diabetic Death Immediate Cause (Final disease Ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27 per me g912 2-2-11 vt X UNPENDED Division of Vital Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown has been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Vunknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other 5 Residence 6 🗹 Other: Scene this ER/Outpatient 3 DOA ဥ 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the nosperator within 24 hours after death.

To the Funeral Director: A 1 X Natural 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allav O.C.M.E. January 5, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAM. 17, 2011 RITA VIRGINIA DUTTON 8:31A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 8040 BILLINGSLEY ROAD WHITE PLAINS If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign MD • Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1-21-1934 Days 217-32-3433 76 1 □ M 2**X**□ F Yrs Director Usual Residence of Decedent fshov 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland er than "natural", or items 23a or 28a-f sho Director WHITE PLAINS MD. CHARLES 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 8040 BILLINGSELY ROAD 20695 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NELLIE LORETTA COOMBS JAMES HARRISON WILLETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20601 ELIZABETH DUTTON-DAVIS-DAUGHTER 8520 RODGELINE TERR. WALDORF, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ST.JOSEPH S CEM. 1-21-2011 POMFRET, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furieral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ischence Physician/ Mseas1 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): cal Box 68760 Physician/Medi f yes, outcome of pregnancy

| Live Birth 2 | Fetal death 3 | Ectopic pregnancy
| Succept at time of death 5 | Other (specify) | IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0033426 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person P.O. Box 2665 La Plata, MO 20646 B. LARRY MID

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month - MAAROUFI 0350 AM 201 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 5600 WISCONSIN CHEV MONTGOMERY HASE Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 016-40-549 Months Days Hours Min. (Month, Day, Director MEROCCO Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 10c, City, Town or Location 10d. Inside City Limits must be notified MD MONTGOMERY 28a-f CHEVY CHASE 1 Yes 2 No 10e. Street and Numbe ö 10g. Citizen of What Country? Funeral 23a 5600 WISCONSIN 20815 USA ral", or items? Examiner mus 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: WHITE other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important If item 27 is marked other than any injury or other transment. Elementary/Seconday (0-12) College (1-4 or 5+) WORLD BANK ECONOMIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٩ BEN BOUAZZA HALIMA BINT 19a. Informant's Name/Relationship (Type, Print) WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN EL-MAAROUFI 5600 WISCONSIN AVE # 18A CHEVY CHASE MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other parts) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State PARK 01/10/2011 ROCKVILLE 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licens 22. Name and Address of Facility ADEN MUSLIM FUNERAL EASY ST. WOODBRIDGE VA. 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Ofiset and Death Immediate Cause (Final -Physician/ Dementra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RUETZFELL JACOBS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy perform Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Certificate: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation
Could not be Accident 1 Yes 2 No filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. inthia M Williams, D.O. H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Upton ST, N.W. CYNTHIAM WILLIAMS, DO State 32. Registra s Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 January 9:15 a^M Tessie Mae Edghill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours (Month, Day, Year) ne 25, 1931 Country) 262-38-4692 GA 79 June Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Rosedale 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21237 U.S.A. 1822 Ellinwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Important: If item 27 is marked other than 'any injuy or other traumatic event, the Marca upon once. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Medical Dietary Aid Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Addie Morgan Burt Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1822 Ellinwood Rd., Rosedale, MD 21237 Charles W. Edghill/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan^{Date} 20 Cremetery, crematory or other place tremation Direct
Service 1 Burial 2 K Cremation 3 K Removal from State 4 Donation 5 Other (Specify) York, PA 2011 Signeture of Funery Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Second St., New Freedom, 24 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WITH BRAIN METASTAS CANCER Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine fram, leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 | Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? YPERTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown DEPRESSIVE DISORDER 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy pade performed? death? 1 🗌 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **N**o Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 2 Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 1 Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 23319 llem MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSE TOWSON MD 21204 OSLER DRIVE NBLE MO 32 Registrar's Signature State Bunk Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 9, 2011 4:05 A Isaiah Dean Fiscus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept 25, 1 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Jenners, PA Director 182-14-2025 Sept Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's TX Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 2108 Charleston Place USA death 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, was becedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 721 Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Operating Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Fiscus Minnie Stahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2108 Charleston Pl., Hyattsville, MD 20783 Renee J. Fiscus - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory : 1/11/2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Korgus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA ASPIRATION Immediate Cause (Final Onset and Death (Inysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARRY THUIA ARDIAC Esquantiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown the 9 Unknown cate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYDERTENSION 1 Yes 2 Probably 4 Unknown CHRISTIPOVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 ANO Yes 2 L 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only on 29b. Signatu and title of certifier 29c. License number D-59 Asurin 01/10/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHVD SHAMIM, UD, WASHT NUCTON ADVENTIST HOSP, TAKOHA PARK 10+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Velma O. Fishpaw January 2011 2:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Taneytown Carroll Lorien Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2/2 F 78 Director 212-30-6379 10-26-1932 MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 ☐ No notified Director PΑ York Glen Rock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or ms 23a 5064 Hildebrand Road 17327 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or Items Medical Examiner mo 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) Keypunch operator Western Auto Pages 1 and 2 should be filed withment of Health and Mental Hygien thant: If item 27 Is marked other thighry or other traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Armacost Hazel Palmer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon M. Ihle, daughter 5064 Hildebrand Road, Glen Rock, Pa. 17327 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State Lake View Memorial 1/6/2011 Sykesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses M00741 934 s. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** Cuks browns /Medical Due to (or as a consequence of) **Examiner** rerevoc Sequentially list curufficions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not he 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) i 24 hours after de e Funeral Directo letely filled in by t 4 Homicide t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

30. Name and a

31. Date filed (Month, Day,

JAN 0 4 2011

DHMH 17 Rev 1/2001

Poole Rd, Westminster,

cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 Î Barry Steven Fettner January 7:38 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 ☑ M 2 □ F Months Days Hours Min. Aug 31, 63 Year 947 Director 064-38-1268 New York Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director Frederick Frederick 1 X Yes 2 No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1718 Dogwood Drive 21701 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ð 1XX Yes 2 ☐ No 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Vietnam 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F 2 Marcia Schuss Theodore Fettner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1718 Dogwood Dr., Frederick, MD 21701 Norma Fettner / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Jan. Resthaven Crematory 4 Donation 5 Other (Specify) 2011 Frederick, Maryland Signature of gneral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gary one cause on each line. Approximate Interval Between Immediate Cadse (Final disease or condition resulting in death) Onset and Death Physician/ Myocardial Infarction Medical Due to (or as a consequence of) Examiner 10 years Atherosclerotic Heart Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Diabetes Mellitus Years attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 1 Yes 2 No Yes 2 X No Il or Attending Physician: after death. Director: After this certific Division of Vital funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) D 24882 January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9093 Ridgefield Dr., #104 Frederick, MD 21701 Ciarkowski, DHUA M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kurt Feldman ANUARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 13 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2 □ F Pennsylvania Director 192-32-9363 68 1942 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be by Funeral 23a U.S.A. 12809 Little Elliott Dr. Apt.4 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Hygiene. other than "natural", 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other th other traumatic event, the Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Herbert Feldman Martha Grace Eckels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene K. Feldman/Wife 12809 Little Elliott Dr., Apt.4, Hagerstown, : If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 🛛 Other (Specify) Entombment Rest Haven Cemetery 1/21/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ myo culled m ha Medical resulting in death) Due to (or as a consequence of): Examiner **پ**ر Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ Pregnant at time of death Month Day Year ed by the a detached f 9 Unknown P.O. sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, mallita Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Acaile this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FINO Certificate: To 1 4 Inpatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ~0 JAN 18, 2010 act 0 (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST m021740 MAGERSTOWN DATTA 10 3 40 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:45PM January 1, 2011 Helen L. Fink /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care at Asbury Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T 476-03-5310 93 Director July 15,1917 MN Usual Residence of Decedent the Maryland 10a State 10h. County 10c City Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or items 23a or 333 Russell Avenue, #212 20877 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√€ No Specify: If Yes, Give Year or Dates: Completed by 3 ☑ Widowed 4 ☐ Divorced er than "natur, 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance Co. Item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry R. Wollin Florence Ann Johnson ۵ 21704 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Hill/Daughter 3651 Spring Hollow Lane, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/3/2011 Department of Important: If it any Injury or o 1 ☐ Burial 2 🛣 €remaţion 3 □ Removal Metropolitan Crematory 4 Donation/ DOtyler (Specify) Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature Funeral 6 ervice Licen 500 University Blvd. W., Spring, MD Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** uve 2 weeks Due to (or as a con uence of): resulting in death) /Medical Examiner eaL.s if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Schemil Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
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4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not, resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dreu Monio autopsy performed? certificate 1 ☐Yes 2 ☐No 1 □Yes 2. No 24 hours after death.

Funeral Director After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∰ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 Mi dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name all ohn Menick 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 04

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 01564 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificat	te of De	eath		_	R	eg. No			
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Medical Exami	ner	William Edw								January 1		111		1111 hrs
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21 Duild to I Men ic eve	2	19a. Informant's Name/Relat	ionship (Type, Print)		19b. N	Mailing Add	ress (Stre	et and Num	ber or Ru	ıral Route Nun	nber, C	ity or Town,	State,	Zip Code)
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Ficalth and Mental Bygiene. It: If item 27 is marked nither than "natural", or items 23a or 28a-f shan other traumatic event, the Medical Cambiner must be notified at once.		Paul Fresch/	Son		590	06 Tr	ystin	Tree	Driv	ve, Med	ina	, OH	4	1256
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Baltimore, MD 21215-0036 permit. Pages i and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Impurtant: If item 27 is marked rather than "natural?, or items 23a or 28a-f shi injury or other traumatite event, the Medical Examiner must be notified at once	- 1	1 Burial 2 X Cremi	_	II OIII Otate		c Crema		ı]	1-1	7-11	Mt.	Holly	Spri	ngs, PA
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		 Name and address of per Ana Rubio MD. 	son who completed cau Assistant Medical			Baltimor	e Street	Baltimor	e MD	21223				
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Sta Registr			2011	was for	1	Billed	1							İ

Amend 16b per FH G911 1/25/11 dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 0 | 5 5 5 State of Maryland / Department of Health and Mental Hygiene

sony Lymm 1 1000m		- For State tegistrar	Ote	ile oi	iviai yiai	iid / L			f Death		ia ivicii	tai i i		g. No.				
Physician	7	1. Decedent's Name (Fi											Date of Deat Month		Year		3. Time of Death 1111 hrs	
Medical Examine											r Location o	of Death	Month January 1	1, 2011 THE S				_
		4242 Gene Her		_	cet and nun	iber)			Jeffers		Location	or Bodan			rederick			
Funeral	7	5. Social Security Numb	er	S. Sex	7	7. Age (I	n yrs. last b	irthday)	If Under			r 24Hrs.	8. Date of Birt	h(MM/	DD/YYYY)	9. Birth Foreign	nplace (State or	
Director		214-30-1198		1M	2XF		7 9	Yrs	Months i.	Day	s Hours	Min.	08-30	-19	31		intry) AR	
any	_	Usual Residence of Dec	cedent			110	c, City, Tov	vn or Locat	ion								10d. Inside City Limi	ts
- Re de	ı	PA	Fran	klir	ı			oensb							1 X Yes 2 No			
larylan 18a-f s 18 on	10e. Street and Number 10f. Zip Code 10g. Citizen									zen of Wha	en of What Country?							
the Man or 2										Ţ	U.S.A.							
th with cens 2:		11. Marital Status 1 Never Married	2 X Ma		. Was Dece Armed For	ces?			as Deceden es, specify				ecify Yes or No- Rican, etc.)		14. Race - White,		an Indian, Black,	
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ours after a stural" saminer		15. Decedent's Educat			Dates:	e comple	ted) 16a	a. Deceder	nt's Usual C	ccupa	tion (Give I			16b. k	Kind of Busi	ness/ir	ndustry	
5-0036 ed within 72 hour hygiene. other than "oate the Medical Exar Corn plefed		Elementary/Secondary (0-12) College (1-4 or 5+)							maker	ing me	s. DO NOT	use rem	eu)		Own H	lome	2	
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica	<u>-</u>	12 years							18.Mother's Name ((First, Middle, N	/laiden	Surname)			_
215 be file atal Hy rked o ent, th	John Roney										Ger	truc	de Smith	ı				
D 21 hould is man	ſ	19a. Informant's Name/F			Print)		1		-				ural Route Num		•			
md 2 sho salth and 2 sho cm 27 is	-	Paul Fres					20b Place		TTYS sition (Name			Dr	Date Med	dina, OH			14256 Town, State	_
Baltimore, oermit. Pages I ar Department of Hec Important: If ite Important: or other trinjury or other tr	1	1 Burial 2 X C	remation		Removal fro	m State	crem	atory or ot				1_1	7-11			-	ings, PA	
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Physician	1	23a. Part I. Enter the dis failure. List only or				used the	death. Do	not enter t	he mode of	dying,	, such as ca	ardiac or	respiratory arre	est, sho	ock, or head		Approximate Interv Between Onset an	
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iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.																	
ted nisit		(Disease or injury that in events resulting in deat			to (or as a	consequ	ence of):							_				
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687 ertifica ding pl		3b. Was decedent preg past 12 months?	nant in the		Live bir	th	e of death	2 Fe	tal death	3	Ectopic	pregna	псу		Month	Da	ay Year	
b. Box 687 the death certific by the attending I ched for use as ti		1 Yes 2 ✓ No 9	Unkr	nown 9			e oi dealii	5 O	her (Speci	fy) _				1				
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ord aw req as bee 2 shou													24a. Was a autop: perfor	sy	prie		opsy findings availab empletion of cause of	
Records, The law requires, freate has been sign, agg 2 should be Completed	5									DI	(D 41-)	/Ob a - l.	1 Yes		0 1	∕ Yes	2 No	
rician: sician: is certi	3	25. Was case referred to examiner?	No Medical	Hosp	ital: 1 In	patient	2 ER/	Outpatient			Other			Reside	nce 6	Other:	Scene	=
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ion itendii leath. tor: / the fi		1 Natural 5 [2 ✓ Accident	Pendi Invest	ng igation	Jan 11, 2	011	11	OUND: 01 hrs -			Yes 2	No t	emperature					
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.		3 Suicide 6	Could	not be	28e. Place (Specify)		- At home,	farm, stre	et, factory,	office l	building, et	- 1	28f. Location (S or Town, Si 1242 Gene He	tate)			al Route Number, Cit	iy
Tospite 4 hour Funers		4 Homicide 29a. Certifier 1 Cert (Check only	tifylna Ph	/sician:			nowledge, c	leath occur	rred at the t	ime, d	ate and pla	- 1	due to the cause			•		_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex		one) 2 Med	lical Exan	lner: On	the basis of manner sta	examin	ation and/o	r investiga	tion, in my	opinior	n, death oc	curred at	the time, date a	and pla	ice, and due	e to the	cause(s)	
F F F S		29b. Signature and title	of certifier								se number						th, Day, Year)	
		اللالا			-1-td		- //L- 00			O.C.	IVI. □.			Jan	uary 12,	2017		
		30. Name and address of Ana Rubio MD.			pleted cause /ledical E				imore St	reet,	Baltimo	re, MD	21223					
Stat	~	31. Date filed (Month, Da			32. Rec	istrar's	Signature	-										
Registra	_	JA	N 2	201	71 De	reacted	- 1	17	ales									_
DHMH 17 Rev 1/2001	1			ſ	CME		0	RIGINA	L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	******	Jr. Si 1- For State Registrar	ate of Maryl	•	ertificate of		and M	ientai F	7.5	Pea No				
Physici		Decedent's Name (First, Midd	lle,Last)						2. Date of D	eath			ime of Death	
lical Exam	iner	George	Albert	Flinn									237 hrs	
		4a. Facility Name (if not instituted 5109 Wilkins Drive)	on, give street and n	umber)	4	b. City, Town Temple		tion of Deat	h	Reg. No. e of Death nth nth Day Pear Pluary 17, 2011 4c. County of Death Prince George's ale of Birth(MM/DD/YYYY) 1 1 0, 1978 100, 1978 100, 1978 100, Inside City Limit 1				
Cumpus		Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1		Under 24Hi	n le Data af l				- Chata as	
Funeral Director		217-31-6348	1	32				lours Mi						
		Usual Residence of Decedent	1 M 2 F	J 32	Yrs.	L į			July	10,	1970	Death Orge's 9. Birthplace (State or Foreign Maryla: 10d. Inside City Limit 1	1 mai y main	
ř <u>i</u>		10a. State 10b. County		10c. City	y, Town or Location	on						10d	Inside City Limits	
d bow a	_	Maryland Princ	e George'	ST	emple Hi	11s							_	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number			cprc III	10f, Zip Coo	de		1	10a Ci	tizen of Wha			
or 28		5109 Wilkins	Drive			2074				109. 01		oodiniy.		
vith th		11. Marital Status		cedent Ever in U	IS 13 Was			Origin2 (S	Specify Yes or N	do-		American I	ndian Black	
eath v item	Funeral	1 X Never Married 2 M	larried Armed F	orces?					Rican, etc.)	10-			idiali, black,	
ner de		3 Widowed 4 Div	1 Yes	2 X No	₁□ .	Yes 2X	No spec	cifv:			Specify:	White		
urs al	Completed by	15. Decedent's Education (Spe	or Dates: cify only highest gra	ide completed)	16a. Decedent'	s Usual Occ	upation (G	ive kind of	work done	16b.				
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working	life. DO N	NOT use re	(ired)					
21215-0036 uld be filed within 7 Mental Hygiene, marked other thun c event, the Medica	ם		3 years		W	aiter				F	ood In	dustr	у	
5-C led w Hygie othe		17. Father's Name (First, Middle		-			18.Mot	ther's Nam	e (First, Middle	, Maider	Surname)		-	
be fi	Be	George Albe		Sr.			Jen	nifer	Rose	enb1	om			
hould hould hould hould he hou	မ	19a. Informant's Name/Relations												
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funnaral Director	- 1	George Albert	Flinn Sr.			Wilki	ins D	rive						
		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal f		Place of Disposit crematory or other		f cemetery.	's	Date	20c.	Location - C	ity or Town	, State	
		4 Donation 5 Other S		Ka	las Crem	atory		1/2	0/2011	E	dgewat	er, M	aryland	
mit. partir ury c		21. Signature of Fana al Service		I	22. Na	me and Add	ress of Fac	cility Ge	orge P.	Ka.	las Fu	neral	ath rge's Birthplace (State or reign Maryla 10d. Inside City Limi 1 Yes 2 X M ountry? Derican Indian, Black, State or reign Maryland State or reign Maryland Pland 2074; or Town, State r, Maryland Pland 20745 Approximate Interval Setween Onset and Death Pland 20745 Approximate Interval Setween Onset	
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e be executed e be executed ysician and burial - transit	dical	▼ UNPENDED	d AMENDED	23a,27	,28a-f p	er me	g912	2-9-	-11 vt					
Box 68760, e death certificate be the attending physicia ed for use as the buria	٣Ì		1 Live b 4 Pregr	nant at time of de own	2 Feta eath 5 Othe	I death er (Specify)		opic pregna	ancy	23		•	Year	
es that the	þ	Part II. Other significant conditi	ons contributing to	o death but not r	resulting in the un	derlying cau	se given in	n Part I.						
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	0	25. Was case referred to medical				26.PI		ath (Check	only one)					
	၂၅	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursir	ng Home 5	Reside	ence 6 🗸	Other: Scen	e	
of ng Ph		27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. Time of Inju	ury 28c. 1	Injury at W	fork?	28d. Describe	how inj	ury occurred			
₹.5	읉	Natural 5 Pending Fd 1-17-11 Fd 12:15pm 1 Yes 2 X No unknown												
tendin eath. for: Ay	37.1	3 Suicide 6 X Could	29a Blac	e of Injury - At h	ome, farm, street,	factory, offic	ce building	ı, etc.	28f. Location	(Street a	nd Number of	r Rural Ro	ute Number, City	
or Attendin frer death. Director: Av in by the fur	릙	Suicide Suicid											, Md. 20	
pital or Attendin ours after death. cral Director: A	Sertific	4 Homicide		st of my knowled					due to the cau	ise(s) an	d manner as	stated		
Hospital or Attendin 24 hours after death. Funeral Director: A etely filled in by the fur	al Certification:	29a. Certifier 1 Certifying Ph			and/or inventiontie	n in my onin	ion dooth		the time date					
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Medical	29a. Certifier 1 Certifying Prone) 2 Medical Example Signature and title of certifier Control State St	and manner s	tated. se of death (Item	n 23a)	29c. Lice O.	ense numb	per		29d.	Date signed	(Month, Da		

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jane Louise Fagan 15^{Day} 201^{Year} Janth. 11:15 A м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Somerford Assisted Living Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F , 1918 <u>Pennsylvania</u> Hours Min. March Day Director 217-10-0941 92 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 ☐ No MD Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2100A Whittier Drive #D-4 21702 United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7; ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Charles Troupe Ada Jane Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7027 Summerfield Drive, Frederick, MD, 21702 Vonda Roberts (Daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Mt Olivet Cemetery Jan 21,2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home MO1612 106 E. Church Street, Frederick, MD, 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Medical disease or condition Jempa resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or ill ijuly that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diahotes Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an blacd autopsy performed? Yes 2 X No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Famb 1- Natural injury work? 1 ☐ Yes 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 51643 17/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD to Pagenons 65 filed (Month, Day, 32. Red State Parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ange1a Julia Geronimo 2011 8:00 P. January Medical 4a. Facility Name (if not institution, give street and number)

Heartland Health Care Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adelphi Prince Georges of Adelphi 9. Birthplace (State or Foreign Country) Republic Dominican 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours 577-11-5697 Director 83 October 1,1927 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct 1 X Yes 2 No Maryland Prince Georges Adelphi 10f. Zip Code ō 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral with 1801 Metzerott Road 20783 Dominican Republic within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 X Yes 2 □ No Specify: Dominicana **Black** If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th grade Domestic Worker Domestic other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Tito Capois Anarita Pool permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Francisca Geronimo (Daughter) 811 Longfellow Street, N.W.; Washington, D.C. 20011 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 23, 2011 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Provincia, de Samana, 4 Donation 5 Other (Specify) Santa Barbara De Samana Cemetery Dominican Republic 21 Ignature of Ineral Service Live mea 22. Name and Address of Facility R. N. Horton Company Morticians, Enc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction 5 minutes Medical Due to (or as a consequence of): Examiner Coronary Artery Disease vears Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the death certificate be executed use as the burial-transi Hypertension vears that initiated events resulting in death) Last Due to (or as a consequence of the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 Duknown 9 Unknown or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage Renal Disease 1 Yes 2 No 3 Probably 4 X Unknown Completed peen Peripheral Vascular Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 2 death? 1 Yes 2 No 25. Was case referred to medical director. æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ospire. 4 hours after deam. Funeral Director, After this c မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Raman R. Tuli, M.D.; 10810 Darnestown Road; Suite 202; Gaithersburg, Maryland 20878 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11, 2011

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 544AM 216500 omas 0 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LISTUUM Washing ton ta If Under () Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ★M 2 ☐ F Months Days Hours Director 05/28/1948 62 MD 215-44-9567 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No Directo MD Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 224 Summit Ave. Apt. 21740 USA Funeral 2W 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Armed Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1966-69 1 ☐ Yes 2 ANo Specify ģ Specify: 3 ☐ Widowed 4 ♣ Divorced **Black** 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 cement finisher construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Gloria Weedon William Henry Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al important: If Item 27 is any injury or other traus 42 Livingstone Terrace, Frederick, MD 21702 Merhl W. Gibson-brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/12/2011 Frederick, MD Hope Hill 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service/Densee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the divea shock, or heart fallure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a cur secure on off Examiner day, Isating to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nellitus 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed of use of death (Item 23a) (Type, Print) 4HOUA 4014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GIBSON Day 20/1 Physician/ NORMA Month 7:13 AM JEAN 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Yo October 3, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Year) 1931 District of Columbia 79 Director 579-42-8741 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified any once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 🗌 Yes 2 💹 No Maryland St. Mary's Avenue 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number 21245 George's Lane 20609 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Accounting Technician 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Mae Robinson Atwell Peter Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32176 77 River Beach Drive Ormond Beach, FL Daughter Linda Gibson Aharon 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bushwood, Maryland 17, 2011 Sacred Heart Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mattingley-Gardiner Funeral Home P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON ST SEGMENT FLEVATION MI Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BREAST CANCER METASTATIC Secuentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ₪ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPERTENSION, DIABETES MELLITU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION, HYPOTHARDIDISM 24b. Were autopsy findings available prior to completion of cause of To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy death? 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number

Opme

DHMH 17 Rev 7/2009

State Registrar St. many's

MD

Registrar's Signature

AKINTIDE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADED OY (N
31. Date filed (Month, Day, Year)

00066995

Hurpital Lemandtonn, mp 2060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2 011 Physician/ Month Jan. 1 4:05 a M Yvonne Gibeily Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11407 Monticello Avenue Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Feb. 5 Year 928 1 M 2 X F Director 364-38-5388 82 Israel Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "nother 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No M D Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11407 Monticello Avenue 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White etc. 1 Never Married 2 Married Completed by Yes 2X No If Yes, Give 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Youssef Maroun Eveline Salime Atallah 20902 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11407 Monticello Avenue, Silver Spring, Joseph A. Gibeily/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan
Crematory 1 Burial 2X Cremation 3 Removal from State Jan. Alexandria, 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 2 days Immediate Cause (Final Physician Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and re burial-n b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): anding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 😿 No Month Dav Year be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atherosclerotic Cardiovascular Disease, 1 Yes 2 X No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an History of Myocardial Infarction, Dementia, autopsy performed? Congestive Heart Failure, Hypertension 1 ☐ Yes 2 ☐ No Yes 2 K No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X X atural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mh D12121 Jan. 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sengstack, MD 3929 Ferrara Drive, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gale trances 1719P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICIMICA SOLISBUKU REGIONAL Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. / 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Min 77 Yrs 220-28-1833 Director Maryland Usual Residence of Decedent 28a-f show 10a State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Somerset Westever 1 Yes 2 No Maryland 5 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 31121 Rehobeth 21871 11. S. A. 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 "natural", 1 Yes 2 No Specify: 3

Widowed 4 □ Divorced Completed Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Private family Home permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Ames Lillian Horse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renobeth Rd Brenda Gale 31147 Daughter Westover, mel Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Marion Station Ind 4 Donation 5 Other (Specify) 15/11 Ebenezer U.M.C. Cemetery 22. Name and Address of Facility Anthony E. 21. Signature of Funeral Service Licensee Ward F. H. €. 30639 Humpolan Princess Anne, Mil 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year detached 9 ☐ Unknown 9 | Ilnknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
Yes 2 No page certificate ! 2 No 1 🗌 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Yes ျင 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 21804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Cert	tificate of Dea	ath		Reg. No.	
Physician/ Medical Examiner	1. Decedent's Name (Fire		N HART	215		2. Date of Month Janua	ry 8, 2011	3. Time of Death 2145 hrs
	4a. Facility Name (if not 304 Aragona Dr		and number)		, Town, or Location of Washington		4c. County of D	rge's
Funeral Director	5. Social Security Number 237-66-18		7. Age (In yrs. las	st birthday) If Ur Mor			-22-1932 FG	Birthplace (State or oreign Country)
te Maryland or 28a-f show any fied at once.		county ANCE GENT	ges for	Fown or Location				10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f sh tified at one Director	10e, Street and Number 304 Ae,	AGONA 3	Derve	10f. Z	20744	L	10g. Citizen of What o	Country?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f aboor or other traumatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2 NASidoused 4		las Decedent Ever in U.S rmed Forces? Yes 2 No Silve Yeer		dent of Hispanic Orig cify Cuban, Mexican, 2 No specify:			
5-0036 ed within 72 hours after tygiene. other than "natural" he Medical Examine Completed by	15, Decedent's Education Elementary/Secondary		est grade completed) llege (1-4 or 5+)		al Occupation (Give lyorking life, DO NOT		16b. Kind of Busine	
MD 21215-0036 to 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than aumatic event, the Medica To Be Comple		, Middle, Last)	✓		161	ADYS 1	EVANS	
MD 21 12 should 1 th and Mer 1.27 is man umatic ev	19a. Informant's Name/F	telationship (Type, Pr * TOLSON	DAUGNTER	19b. Mailing Addre	AVE HEAD	DR. Upp	Number, City or Town, S W HAR (60%),	40 20774
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 1/4/2011 Year Physician/ P^{M} 1:00 MARIE HOWARD **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE CASEY HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Tuscolusa, 3/8/1916 1 🗆 M 2 😾 F Director 94 <u>578-26-5607</u> Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Maryland that Hyglene. As the than "natural", or items 23a or 28a-f shon event, the Medical Examiner must be notified at 10a, State Director 1 Yes 2 No Prince George's <u>Hyattsville</u> <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 20782 5802 Maryhurst Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 K Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Private Housewife Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumative. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cora Jane Lightfoot Reed Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9386 Breamore Court Laurel, Maryland 20723 Early Howard / Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State n Memorial 1/14/2011 Suitland, Maryland
22. Name and Address of Facility Pope Funeral Homes, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final a COLO-RECTAL CANCER WITH METASTASES Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death ate has been signed by the attendin page 2 should be detached for use a 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHRENIA Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes 2x No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2x No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 1/4/2011 D 37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman 1355 Picard Drive Suite 100 Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 50AM Davi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Montgomery

9. Birthplace (State or Foreign Country) <u> Althea Woodland Nursing Home</u> Spring 8. Date of Birth **Funeral** (Month, Day, Year) 1 🗆 M 2 🔀 F Hours Director 416-42-7618 82 Alabama Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 XYes 2 No MD PG Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Colton Street <u> 20774</u> United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Registered Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Derry Wilson Katie Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Colton Street Diane Hipkins Duncan/daughter 20774 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
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once. 1 Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cemetery 1/10/11 Suitland, Md 21. Signature of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerote Cardiovasulur Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Wo 5 Other (specify) Month Day Year signed by the at Id be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 XNO 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Queensbury Rd HyaTT Sville MA 4203 31. Date filed (Month, Day, Year, 32. Registra State JAN 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:00 P M Georgie Molly Hawkins 10 2011 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Hughesville 6186 Trotters Glenn Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 Months Days Hours Min. **Director** 217-36**-**6837 01/15/1937 Washington D.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏋 No Hughesville Maryland Charles 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20637 S Α 6186 Trotters Glenn Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates 3 Widowed 4 XDivorced Completed nd Mental Hygiene. marked other than "natur imatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Property Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ should be other traumatic Norman Miller Rosabel Munger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 6186 Trotters Glenn Drive, Hughesville, MD 20637 Jennifer Dill/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State Brinsfield-Echols Crem 01/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, PA Signature of Funeral Service Lice 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ END COFD STACKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SETZULE DISURDER Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed OSTEO PORO SIS and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? cate has been signed page 2 should be det þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 12 No certificate within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, t 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 14 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending М Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 067814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPFITAL ROAD STE 201 20678 PRINCE FREDERICK MO FRANCISCA 130 BRUNCY

State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, 2011 Physician/ January 10:48 AM Halbe Patricia Connors Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Seabrook 9300 Woodberry St. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 🗆 M 2 🔀 F Days Hours Dec. 30 1928 82 Pennsylvania Director 159-24-2903 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 93a or 92o 6 6 mm. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No. Seabrook Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 U.S.A. 9300 Woodberry St. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant FBI and CIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Dougherty John Connors traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 Woodberry St. Seabrook, MD 20706 William Halbe (Husband) other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State jo : 1 X Burial 2 Cremation 3 Removal from State permit. Page 1 Department of Important: If i any injury or or 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cem. 1/10/2011 Silver Spring, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or imjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? this certificate 1 Yes 2 No 25. Was case referred to medical iours after death, erral Director; After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be examiner's Hospital Other: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No М Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number D55559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MASUL 4TEN 1525 パリアノイシン 31. Date filed (Month, Day, Year) State JAN 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Рм TARFIELD 8:48 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Months Hours (Month, Day, Yes North Carolina 92 Director 411-07-9308 June 1918 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 1229 Cross Road USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc 1 Never Married 2 X Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify. Specify: Black 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Lental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Film Projectionist DC Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should re f Department of Health and "suta Important: If item 27 is marked any Injury or other traumatic ex Pearl unknown unknown, Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice E. Hunt / Wife 1229 Cross Rd Annapolis, Md 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery: 1/10/11 Brentwood, Md. Signature of Funeral Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home reia 1 3401 Bladensburg Rd Brentwood, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Immediate Cause (Final Onset and Death Chysician, ardio m disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner clasteral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🔲 No been signed by the should be detached 9 Unknown 9 Unknown P.O. | or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣️ Unknown dianhea 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has prior to death? performed doutic arch certificate 2 🗌 No 1 - Yes Yes 2 No Division of Vital To the Funeral Director: Atter this certure completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔲 No 2 1/X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/1/2011 D 43371 Madical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 H. Joseph-Herbert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 A^{M} Margaret Elizabeth Holmes 0519 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛱 F (Month, Day, Yea West Virginia Director <u>217-</u>60-0195 59 July Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must be not the contraction. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 156 Hollingsworth Manor United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vernon Alt Ada M. Cosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Holmes/Son 108 A Hollingsworth Manor, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 15, 2011 4 Donation 5 Other (Specify) West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit iver or that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 1 Yes 2 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 . No ပု 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Karen J. LeFrak, M.D. 31. Date filed (Month, Day, Year) 32. Regi State

DHMH 17 Rev 7/2009

Registrar

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B 6 9 44		29a, Certifier (Check only 1 Certifying P	hysician: To the be	est of my knowled	lge, death occurr	ed at the tim	e, date	and place	e, and d	ue to the ca	use(s)	and manner	as stated	nauea/e)	
Hos 24 h Fun	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated. 29b. Signature and title of certifier 29c. License number								ine time, dat		place, and d			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	- 51	29b. Signature and title of certifi	er			- 1					- 1	_	,	i, Day, reary	
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To the Hos within 24 ho To the Fun completely		30. Name and address of person	who completed car	use of death (Item	n 23a)		.C.IVI.		_	_			, 2011	TO A	

Examiner spital or Attending Physician: The law requires that the death certificate be executed tours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records, Hospital

Funeral

Director

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Procted any injury or other traumatic event, the Procted once.

Physician

/Medical

Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manne stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and address of person who completed cause of

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Date filed (Month, Day,

DHMH 17 Rev 1/2001

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Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 438 SRACE UDNES 2011 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MT. ALRY KLONE HOSPICE FREDERICK HOUSE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🔀 F Days Hours Min Director 172-24-8940 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NEWRURC FRANKI 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17240 16035 RURNT MZZ 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced WHETE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Be other traumatic event, permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is progressing injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ OVMER STOUFFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALYSON GLEN BROOK DZ. MEDDLETOWN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-13-2011 CHAMBERSBURG PA MARKLAWUS MONGROV GARDOS 21. Signature of Funeral Service Licens 22. Name and Address of Facility TOSELLANGER - BROCER F. N DVC. PORON SE SHEPPENSRURG PA 17257 57. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ rea disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: completed filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XVNatural work? injury 5 Pending Accident
Suicide
Homicide 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 6810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 pM0.12011 12:50 Mary Angeline Jiron Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 1719 Merrimac Drive <u>Hyattsville</u> 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🏲 F (Month, Day, Year) 08/16/1930 Hours Director 80 578-38-4603 Detroit, Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified 1 ¥ Yes 2 □ No MD Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of What Country? Funeral 1719 Merrimac Drive 20783 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or. ò 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 To No Specify. Specify: "natural" Completed 3 X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Scottish Rite Mail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve James Limox Johnnie Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Selliah - Daughter 20783 1719 Merrimac Drive Hyattsville, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 01/08/2011 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month for Month Year Day Pregnant at time of death the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ★ Yes 2 No 3 Probably 4 Unknown Hypercalcemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia has autopsy performed? Yes 2X No certificate 1 🗌 Yes 2 🗆 No Renal Failure funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62063 01/07/2011

State Registrar 4207 Park Center Drive #102 Laurel, MD

20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Jenel Wyatt,

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 Edward B. King 02 2011 Medical 5:10 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8513 Pinta Street Clinton Prince George's Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth 1 3 M 2 □ F Director Days 579-42-2136 Hours 03/01/1933 77 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Capitol Heights 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 7226 Hylton Street 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No If Yes, Give TT Black, White, etc. 3 Divorced Completed 1 ☐ Yes 2 🔀 No Specify: UNKNOWN Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Law Enforcement Officer years GSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ BERNARD CHILDS SARAH KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Erik King -</u> Son 4859 W Slauson Ave Los Angeles, CA 90056 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) MD National Cemetery 1-8-2011 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home may 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 9 years Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Pancreatic Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? certificate death? 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ဂ္ 1 Tyes 2 🔀 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Friends Home this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea.. al Director: After 1 🗷 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cynthia m Williams, DQ H0058032 1-6-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, 3720 Upton St NW Washington, DC 20016 DO 32. Registr, 's Sign State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7^{Day} Physician/ JYM. 201^{Yea} 10:24PM SCOTT STANLEY KALSKI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthum Country) W I **Funeral** Min. 1 2 M 2 🗆 F o*†"/"1"8"/*"1"9"58 52 394-62-8315 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland notified at rector 1 Yes 2 No 28a-f POOLESVILLE MD MONTGOMERY ö 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò must be r Funeral 20837 USA 18413 BILLEK COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iten edical Examiner Armed Forces?

1 ☐ Yes 2 ☐ No Black White, etc. 1 ☐ Never Married 2 ☑ Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry HUGHES NETWORK I Hygiene. other than " rent, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) SYSTEMS NETWORK ENGINEER other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be filt Department of Health and Mental I Inportant: If item Z7 is marked c any injury or other traumatic eve one. ပ LORRAINE WILL CHESTER KALSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18413 BILLEK CT., POOLESVILLE, MD 20837 LINDA KALSKI / SPOUSE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01/097201 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY FREDERICK, 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral de vice Ligensee P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SPREAD OSTEONECROSIS a. WIDE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ACUTE LYMPHOCYTIC LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death signed by the a d be detached f Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? eral Director: After this certificate ifilled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and of the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge. within 24 hours a To the Funeral I Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060634 JAN. 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINDU JOŠEPH, MD 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20855 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

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Funeral Director	5	i. Social Security Nu 165-18-	o 4 2 3	6. Sex	2 🗆 F	Age (In yrs. la 93	as <i>t birthday)</i> Yrs.	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Mar 18	th y, Year)	917		hplace (State untry) PA	or Foreign	
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/lanc	۵	George	Josep	h Ko						Ann	a F	atula						
Maryland d 2 should be filed alth and Mental Hy n 27 is marked off er traumatic event		19a. Informant's Name/Relationship (Type, Print) - Wife Elizabeth Amelia Kovich 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Elizabeth Amelia Kovich								state, Zir r S	pring	20904						
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show importants of the traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2 4 Donation	Cremation		oval from St		Place of Disp cemetery, cre ropo			emat		Date Jan. 3 2011				Town, State	Α	
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● Ø 7 1		30. Name and addi		who comp	eleted cause	of death (Iter	m 23a) (Type	Print)				05, S:					ID 209	
State Registra	e	31. Date filed (Mon				jistrar's Signa												

11-00146 Michael Deangelo L	Please Type or Print in Black Indelible Ink. State of Maryland / Department of He		egible. 2011 01588
	1- For State Certificate of De Registrar	ath	Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Deangelo Layn Michael Deangelo Layne	e Jr. 2. Date of De Month January	Day Year 0010 has
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Funeral Director	579-21-7154 1\(\text{M}\text{M}\text{2}\(\text{F}\) 19 Yrs. \(\text{Mc}\)		8, 1991 Sirthplace (State or Foreign Country) DC
Maryland 28s-f show any d at once. rector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's 10c. City, Town or Location	Temple Hills	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?
15-0036 Ifled within 72 hours after death with the Maryland I Hyggene. Ad other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once. Completed by Funeral Director	3910 Triton Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	20748 edent of Hispanic Origin? (Specify Yes or Necify Cuban, Mexican, Puerto Rican, etc.)	United States
2 hours after deati "natural", or ite	1 Yes 2 No 1 Yes 3 No 1 Yes 2 No 1 Yes 3 No 1 Yes 3 No 1 Yes 3 No 1 No 1 Yes 3 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	2 No specify:	Specify: Black 16b. Kind of Business/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	working life. DO NOT use retired) nemployed 18.Mother's Name (First, Middle,	None Maiden Surname)
1215 the file ental Hy rrked o vent, th	Michael Layne Sr.	Tracy I	
2 should and Me 27 is ma matic or		ess (Street and Number or Rural Route Nu ton Court Temple Hi	
MOre, N Pages I and i ent of Health nt: Witem	20a. Method of Disposition 1	Name of cemetery, Date ce) January 14	20c. Location - City or Town, State
	1. Signature of Funeral Servic Dansee 22. Name a 4001.	^{nd Address of Facility} Stewart I Benning Road NE Was	Funeral Home, Inc.
Physician IW dical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Blunt Cardiac Trauma Due to (or as a consequence of):	de of dying, such as cardiac or respiratory a	rrest, shock, or heart Approximate Interval Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
executed an and al-transit ical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
8 2 2 2	UNPENDED X AMENDED 1 per me g912 2-	7-11 vt	1004 Day of 45 ar
certi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 5 Other (\$ 9 Unknown		23d, Date of delivery Month Day Year
r, P.O. Bo; ires that the deatl signed by the att to be detached for the by Physical	Part II. Other significant conditions contributing to death but not resulting in the underly		tobacco use contribute to the cause of death? es 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the attered in by the finneral director, page 2 should be detached for usrtification: To Be Completed by Physical Divisions of the completed by Physical Divisions of the Completed by Physical Divisions of the Completed Branch Divisi		perf	s an ppsy prior to completion of cause of death? 2 No 1 Yes 2 No
Vital ysician his certi directo	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director. After this certific apletely filled in by the funeral director, lical Certification: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 2 Accident Investigation	28c. Injury at Work? 1 Yes 2 No 28d. Describe Subject sh	a how injury occurred ot
Division or Sepital or Attending hours after death. Inneral Director: After y filled in by the function. Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify) Local Street	or Town, 4001 Norcro	ss Street, Temple Hills, MD
DIV To the Hospital or within 24 hours after Too the Funeral Director Completely filled in Medical Certifi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.		e and place, and due to the cause(s)
	29b. Signature and title of certifier Carol Hullar	O.C.M.E.	29d. Date signed (Month, Day, Year) January 5, 2011
10-	Name and address of person who completed cause of death (Item 23a) Carol Allan, MD	e Street, Baltimore, MD 21223	
State Registrar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ January 3 201 1 7:37P M Virgie Μ. Ly1es Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 9. Birthplace (State or Foreign 8. Date of Birth
(Month, Day,
July 16 If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) **Funeral** Min Maryland 1 □ M 2 🛣 F Hours 212-26-7217 88 **Director** Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X☐ No Clarksburg Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Numbe Funeral U.S.A. 20871 Box 122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11 Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married by Yes Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) House Cleaning Service Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dessie Mae Smith Benjamin Lyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Box 122, Clarksburg, Maryland Anna Mae Smith - Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Pleasant Grove Cemetery 1/13/2011 Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Signature of Inneral Service Licensee Kovert 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ fcute myocardial minutes Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 14 Natural work? 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Investigation Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certif who completed cause of death (Item 23a) (Type, Print) 30. Name and/addres s of p Car Dr MD ffman 9901 Medical 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day -Month 11:52a M Lee Lippold Janu Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death La Plata Medica Center Charle Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Unde 8. Date of Birth **Funeral** Month, Day, Your 122 1 🗆 M 2 🗓 F Min. Director 93 229-24-5999 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10200 LaPlata Road 20646 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other transmitted. Homemaker Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Elizabeth Green Ira Kytchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B804 Samuel Mudd Road, Waldorf, MD 20601 Lois E. Mudd/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Trinity Mem. Gardens | 01/11/2011 | Waldorf, Maryland 21. Si m ure of Funeral Service Licence 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Due to (or as a noneequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? Natural Accident 5 Pending the Funeral Director: After the Funeral Director: After the funeral filled in by the funeral fil 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature a 29d. Date signed (Month 2011 leted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 2:15 PM Daniel S. Lee Varyar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours California 11/19/1917 93 573-46-3634 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ħ death with the Maryland Director Examiner must be notified 1 Yes 2 X No College Park Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number Funeral items 23a 20740 U.S.A. 7411 Wellesley Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Asian Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Med College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Voice of America Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Sewchor Lee Tuiken Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7411 Wellesley Drive, College Park, Maryland 20740 Gertrude Lee - Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Baltimore Crematory at Loudon Park 1 Burial 2 X Cremation 3 Removal from State 01/05/2011 Baltimore, Maryland 4 Donation 5 A Other (Specify) of Fineral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in jach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions rany, saving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician a s the burial-t Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>수</u> 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ျှ completed Ause of death (Ity m 23a) (Type, Print) 8118 GoodhuckRd, Carkam, MD. 20706 Registrar's Signa State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Lucille Minor 01 - 03 - 20114:45 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cresent City Nursing Home Prince Georges Hyattsville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗓 🟋 Hours Min. 84 02-17-1926 Director 579-32-1063 Wash, DC Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercitor must be notified at Director 1 X Yes 2 No MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9526 Knight Court 20772 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: \$ Black Specify: XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\,\text{th} \end{array}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, I'm. Nurse Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Atcherson Selma Thompson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Moore-Daughter 7603 Flam Court, Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 1-10-2011 Suitland, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signa e of Funeral Service Livensee 7474 Landover Road, Landover Maryland 20785 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neart **Physician** ongestive disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Kenal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 1 □ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0058095 30. Name and addless of person who mpleted cause of death (Item 23a) (Type, Print) East-West Highway, 31. Date filed (Month, Day, Year)

State

Registrar

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:02A M Gertrude M. Miles Medical Januarv 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7006 Vismanço Lane Clinton Prince Georges Social Security Number 8. Date of Birth (Month, Day, Ye If Under 1 Yea Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 SF Hours Country) Wash 77 Yrs. **Director** 579-46-4473 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director must be notified 1 Xes 2 No MD PG Clinton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7006 Vismanco Lane 20735 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural" 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarence Washington Mildred Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Vismanco Lane Carl Miles/husband Clinton, Md. 20735

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Park 1/8/11 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1/E fet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Pulmonary Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a nonsequence of) that initiated events resulting in death) Last Due to (or as a consequence of) ng physician ar Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Systemic Lupus Erythematosus Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo 24a. Was an autopsy performe Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ြု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? I Director: After t d in by the funera 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD11903 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St., NW#315, Washington, DC 20010 Irring 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2011 10:09 AM January John H. Mason Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 X M 2 □ F Months Days Director 220-62-8422 Sept. 3, 1953 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shor 1 Yes 2 No Director MD Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8124 Streamwood Drive 21208 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 TxNo Specify: 2 Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Body Shop Manager Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Mason Sr Louise Herbert ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8124 Streamwood Drive
Pikesville, Md. 21208

20b. Place of Disposition (Name of cemetery, crematory or other place) Donna Mason/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Sacred Heart Cemetery 1/7/11 Bushwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part r. 5 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute mocardial marction 16 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiently in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Cealia Yshii - Tarnasho RES-000 January 2,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Cecilia Yshij-Tamashiro

Hospital et

Sinai

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:05 A M Physician/ Josea Moolinaar January 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Mechanicsville 42293 Allison Drive 9. Birthplace (State or Foreign Country) Virgin If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth . Social Security Number **Funeral** Days (Month, Day, Year) April 16 1916 1 X M 2 ☐ F 94 Director 215-76-8362 Teland Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 K No Mechanicsville St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral U.S.A. 20659 42293 Allison Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 X Yes 2 □ No Specify: Hispanic Specify: Hispanic 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) filed within Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or ం Unknown Unknown other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42293 Allison Drive Mechanicsville, Maryland Ronald Lee Hutchens, Sr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 10, Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Ligerise Victorel X 20650 P.O. Box 270 Leonardtown, Maryland /ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclenotic Immediate Cause (Final Careliovascular diseas Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months? Pregnant at time of death 2 No been signed by the a a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prisupplusency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an Anaemiceautopsy performed? Yes 2 1 page 2 death? Dementia 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital funeral director. Other: 4 Nursing Home 5 Residence Caregiva 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: 5 Pending 1 🗹 Natural Accident Investigation within 24 hours after death

To the Funeral Director; and completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical l 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar eyan

31. Date filed (Month, Pay,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale

Churchton

32 Registrar's Signatur

D-50653

C. SURANA

GYAN

RUAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ McNutt Victoria Paula 2:10 a January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Mary's Mechanicsville <u>37720 Frischolz Ct</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Hours (Month, Day, Country) Michigan 1 D M 2 X F Yrs **Director** 29,1938 379-36-8526 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral USA 20659 37720 Frischolz Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Theresa Eleanore Adamusik Howard Paul Keider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26251 Mechanicsville Rd., Mechanicsville, MD 20659 Gail W. Buckler/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Mem. Gardens | 01/14/2011 | Waldorf, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Lice MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 5 years COPD Sequentially list conditions, if any, leading to immediate cause. Enter the region Cause (Disease or linjury Examiner Due to (or as a consequence of) 7 years anding physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed CHF that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 1 Yes 2 g Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. ✓ 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 4 ☐ Nursing Home 5-☐ Residence 6 ☐ Other (Specify) ဂ္ဂ 24 hours after death.

Funeral Director; After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ë Natural 5 Pending injury Certifical 1 Tes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature

Jyoti

d title offcertifier

Shah, M.D.,

ddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

34035 Three Notch Rd., Hollywood, MD 20636

B63314

01-10-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Tear 2:59 p M Meiser January Μ. Florence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Callaway Hospice House of St. Mary's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 87 183-18-5494 Pennsylvania **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 V No Lexington Park Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20653 USA 23245 Dillow Court 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Examiner Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" 3 X Widowed 4 ☐ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Air Conditioner Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Manufacturing permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Percy N. Shepp Florence Renaut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23245 Dillow Ct., Lexington Park, MD 20653 Thomas Meiser/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State York, Pennsylvania Mt. Rose 01/14/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Service Licenses Ford N. Brinsfield, 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ PIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) MONTHS Examiner DULMONA Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Yes 2 No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hountee examiner? Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 House After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work' s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b, Signature and title of certifier 1-10-11 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RATHUN H. S. GILL SMA ASSOCIATES MOREYWOOD MD 20636. 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Susie Mills 9:40 PM 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Director 212-26-9031 83 Yrs. October 6, Maryland Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 🏻 No St. Mary's Leonardtown <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? 42700 Moll Dyer Road 20650 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Laundry Attendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Daniel George Mills Mary Madeline Hebb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42700 Moll Dyer Road, Leonardtown, MD 20650 Edith Elizabeth McFadden / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State January 22, 4 ☐ Donation 5 ☐ Other (Specify) Our Lady's Cemetery 2011 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. of Funeral Service P.O. Box 270, Leonardtown, MD 20650 23a. Part (. Enter the disease, of compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Ph sician/ OWE Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit men that initiated events resulting in death) Last by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Pregnant at time of death Month Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signification 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No Director: After this certificate ivision of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Syresh

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh H Partel MD 22656 Cedan (4ne C)

gistrar's Signature

D m

Parte

062213

29d. Date signed (Month, Day, Year)

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 0 11 Jan. Physician/ 7:50p M l, John David McNickle, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Montgomery Hospice-Casey House Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min (Month, Day, Year) eb 4. 1958 Feb IL Director 579-88-4287 52 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 X No Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number the Medical Examiner must be items 23a Funeral 20817 USA 9405 Bulls Run Parkway death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ō, ģ 1 X Never Married 2 Married Specify:White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Services Cafeteria Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Colette Marilyn Meyer John David McNickle, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic or other traumatic 19a. Informant's Name/Relationship (Type, Print) - Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20817 9405 Bulls Run Pkwy., Bethesda, Colette M. McNickle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gate of Heaven 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery Silver Spring, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Prancand Address of Facility lins Funeral Home W., Silver 000 University Blvd. Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Dementia Physician/ yrs. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): 1-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performed's death? 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other:
4 Nursing Home 5 Residence 6 Other (Specify) 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes ျပ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred al or Attending P s after death. Certificate: Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Aftermorpheted filled in by the fu 1 Yes 2 No Investigation Accident 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan. 2, 2011

Registrar

person who completed cause of death (Item 23a) (Type, Print)
eman, MD 1355 Piccard

Coleman,

30. Name and address

D37142

Piccard Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 1055 A M Connie Mae Mills Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Cecil Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X Months Days Hours Min. DEC 21, 1943 Virginia Director 67 213-46-1780 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 21921 United States 114 Parktowne Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Checkout Supervisor Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Hart Ella Mae Neal and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health al
Important: If item 27 is
any injury or other trau Jerry C. Mills/Husband 114 Parktowne Drive, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of Gilpin Manor Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition January 1 $\overleftarrow{\mathbb{X}}$ Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 2011 20. Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Balancia Physician MARIC disease or condition resulting in death) DND Medical Due to (or as a consequence Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown q | | | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? injury 5 Pending 2 🗌 No s after death. Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ P.V. Nay- N Doo 65 733 18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) smut, FILTIN, ND -21921 V- PULA 126 A E. 11164 NARAYANA RAD 31. Date filed (Month, Day, Year) 37. Registrar's Signature State 201 ark Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eldon Eugene Miller 53 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**▼** M 2 □ F 215-36-5863 **Director** 71 1939 Maryland Usual Residence bf Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16491 Spielman Road 21795 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Energy Plant nit. Page 1 and 2 should be filed wit artment of Health and Mental Hygie ortant; If item 27 is marked other injury or other traumatic event, the injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Clarence H. Miller, Sr. Martha P. Spielman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara R. Miller (Wife) 16491 Spielman Road Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State January 4 Donation 5 Other (Specify) Smithsburg Crematory Smithsburg, Maryland 18. 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician a SEPSIS disease or condition HOUR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events ECURRENT SOWEL SMALL attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PHEUMONI 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? STRUCTIVE has autopsy performed FIBROSI certificate PULMONARY 2 🗆 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျ ER/Outpatient 3 DCA Inpatient 2 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1, Natural Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination.and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 138892 49 11110 MEDICAL e of death (Item 23a) (Type, Print) 30. Name and address of person who completed caus CAMPUS 31. Date filed (Month Registrar's Signature State 4

Dr

CA DHMH 17 Rev 7/2009

Registrar

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		30. Name and add	dress of person	on who complete ssistant Med	d cause of ical Exa	death (Iten miner	n 23a) 900 W . I	Baltimore	Street	, Baltimore, M	D 21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Owens Elizabeth Agnes January 6:20 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 48956 Spring Ridge Road Lexington Park St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 🗆 M 2 🖾 F Months 03/30/1926 Yrs **Director** 84 217-64-9039 Usual Residence of Decedent show 10a. State 10b. County ä 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 Tes 2 K No Maryland St. Mary's Lexington Park 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 48956 Spring Ridge Road 20653 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: White er than "natur ; the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ್ತ James 0scar Redmond Mary Edna Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Elizabeth Browne/Daughter 48956 Spring Ridge Rd., Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. James 01/10/2011 Lexington Park, MD 21. Sign and F. eral solice Lee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying signed by the attending physician and I be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perforn death? the perten Mà 1 🗌 Yes 2 No Yes 25. Was case referr 26. Place of Death (Check only one) Be examiner? Hospital 2 40 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 🗌 Yes 2 🗌 No Accident 24 hours after deatl Funeral Director: Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 15626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO TEL 31. Date filed (Month, Day, Year) State Registrar's Signatu

Registrar

JAN 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PRICE Jan Physician/ 2 0 1 1:35 AM 1.15A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death BALTIMORE CITY SINAI HOSPITAL OF BALTIMORE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours DEC. 3 TTALY Director 220-92-7745 47 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 X Yes 2 No MARYLAND FREDERICK MT. AIRY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral UNITED STATES 1120 SHAFFERSVILLE ROAD 21771 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK "natural" 3 Widowed 4 Nivorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Met Elementary/Seconday (0-12) College (1-4 or 5+) SALES ASSOCIATE 12 BRIDAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ AUBREY M. KENNEY ROSAMARIA SCANDURRA 19a. Informant's Name/Relationship (Type, Print) 199 M5 in TOWNESt CENTRE beBLVD! RouteUNTIT, C10173wn, State, Zip Code) ANNAPOLIS, MARYLAND, 21401 AUBREY M. KENNEY/ FATHER 20a. Method of Disposition 20c. Location - City or Town, State 2CHESAPEARE, CREMATION JAN. D8, 1 Burial 2 X Cremation 3 Removal from State CENTER 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FENTOWS Addree FENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Massive hemorrhagie CVA at midbrain and Pons Ph sician/ disease or condition resulting in death) 45 day Medical Due to (or as a consequence of): Examiner months uncontrolled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 X No 1 Tes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No 1 Inpatient 2 KER Outpatient 3 IDOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | | 3 | | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 0 0 5 3 9 2 8 29d. Date signed (Month, Day, Year) Befur 2011 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEQUM W. BELVEDERE AVENUE, BALTIMORE MD - 21215 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 7° 201 1 ear Physician/ 6 Am M Joseph V. Payne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Ridderwood Nursing Home 9. Birthplace (State or Foreign Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8 Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days New York. 16972371927 83 057 22 6636 Director Usual Residence of Decedent 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director Yes 2 No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20906 3160 Gracefield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5years Elementary/Seconday (0-12) Government Dentist ed other event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked othany injury or other traumatic event မ Ermyn Brown Joseph V. Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14001 Tollison Drive, Bowie, Maryland Donna M. Wilson Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cem 01/11/2011 Laurel, Maryland 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home LLC 20017 Washingto, DC 3005 12th St., NE Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached f 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 🔁 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🔁 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 K Natural 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 201 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 20904 3160 Gracefield Road, Silver Spring, MD Eileen Gemmell 31. Date filed (Month, Day, Year, State JAN 1 1 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ Рм Pagenhardt Cook 2011 Dorothy January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mary's ${ t Scotland}$ 49976 Long Neck Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country) District of 7. Age (In vrs. last birthday Funeral Davs 1 □ M 2 🕱 F Months Hours 87 Yrs. Director 1923 Columbia 579-18-3778 June Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Scotland Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö must be n Funeral USA 49976 Long Neck Road 20687 items 2 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, n "natural", or iten ledical Examiner r 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates. Completed 3 ☒ Widowed 4 ☐ Divorced and 2 should be filed within 72 hour Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Frederick Cook Jean Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 13001 Dunhill Drive, Fairfax, VA 22030 Robert F. Fowler / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date January 4, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2011 <u>Alexandria, Virginia</u> ture of Euneral Service thens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Senile EMENTIA EANS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month for Year 4 Pregnant g Unknown Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy certificate has performed death? 1 Yes 2 1 Yes 25. Was case referred to medical Division of Vital director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 1 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural iniury work? 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursa Fractionar is the best of my in ownedge seath occurred at the time, actually later, and share the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier vice m. Julister MC 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar David Federle, MD.,

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

24035 Three Notch Road, Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Year Dorothy E. Prince 23:10 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Yo Oct • 24 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. 195-28-8031 89 1921 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director notified 28a-f Md. Montgomery Laytonsville 1 Yes 2 No o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 20882 United States 28701 Greenberry Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: White Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Receptionist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Young Anna Elizabeth Reuben Thompson item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28701 Greenberry Drive, Laytonsville, Md. 20882 permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau Patricia A. Frye / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 1/11/2011 Laytonsville, Md. Laytonsville Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home
P. Q. Box 5038, Laytonsville 21. Signature of Funeral Service Licensee Xou Soule 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death aspiration pheumonia Physician disease or condition resulting in death) Medical Due to or as a consequenc (of): Examiner encephalopath Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury cerebellar neoplasm the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2-N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔊 No 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🔲 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work?
1 Yes 1 🖺 Natural 5 Pending 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) om MD 00067386 Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orive Rockville, 9901 Medical Center MO Sonia John, 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 Christian

DHMH 17 Rev 7/2009

Registrar

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Argary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗅 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2 ay 201 Year Physician/ 6:30 A M Ethel PERL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Kensington Park Assisted Living Kensington 8. Date of Birth Mar. 155, 1918 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Hours Newmyork 1 🗆 M 2 👽 F 92 098-09-2305 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 ☐ Yes 2 🂢 No Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20895 United States 3618 Littledale Road ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces/? Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates white "natural", 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ury or other traumatic event, the Medical.I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Stephen Behr Anna Weiss 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 2006 GTen Ross Road, Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type, Print) Peter Perl, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/03711 permit. Page 1
Department of Important: If it any injury or or once. 1 X Burial 2 Cremation 3 X Removal from State David Memorial Garden Ft. Lauderdale, FL 4 ☐ Donation 5 ☐ Other (Specify) Signature of Inneral Service Lie Torchinskysshebbew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Year and Death Immediate Cause (Final disease or condition Alzheimer's Disease Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Box 68760 attending philographics at the second IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital 2 XNo Other: Assisted 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di this Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D 09834 15 3

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave., Kensington, MD Barry N. Rosenbaum, M.D., 3720 Farragut Ave., Kensington, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5
State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day 2011 Jan. Francoise Josette Poli 1, 9:15 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health and Rehab. Bethesda Montgomery Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Indings. **378 -** 64 - 6433 1 🏝 M 2 🗆 F Months Days Hours Min. Mar 22, Year) 1928 Country) France 82 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Montgomery Kensington 1 ☐ Yes 2 X No ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3618 Littledale Road 20895 France items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc þ 1X☐ Never Married 2 ☐ Married Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72...h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Embassy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Felix Poli Madeleine Berthe Berth any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Friend and 2 sl Health a mportant: If item 27 2400 Lake Avenue, Cheverly, MD 20785 Richard L.

20a. Method of Disposition Molineaux Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other place)
Metropolitan
Crematory 20c. Location - City or Town, State Page 1 Department of 1 Burial 2 Cremation 3 Removal from State Jan. 4 Donation 5 Other (Specify) 2011 Alexandria, 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD ames Part 1. Iter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cervical Spinal Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Atherosclerotic Heart Disease that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician Physician/Medical Congestive Heart Failure Box 68760 as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the a should be detached t P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 💭 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: XXNatural 5 Pending Accident Division 1 Tes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53691 Jan. 3, 2011 1 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 3200 Tower

Registrar DHMH 17 Rev 7/2009

State

Reddy,

Afay 31. Date filed (Mont MD

Registrar's Signature

Oaks

Blvd. #110, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:27 PM RALPH G. PUCKETT 2011 Medical anua (4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Med. Center Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F *4728*44933 Maryland 215-32-8629 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Harford Pylesville MD 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 250 Wheeler School Road 21132 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify:. Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Antique Furniture Refinisher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Walter G. Puckett Zita Lee Halsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally W. Puckett/Wife 250 Wheeler School Rd., Pylesville, MD21132 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 1/17/2011 Darlington Cem. Darlington, MD 21. Signature of Juneral/Service/Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. nterval Retween Onset and Death Immediate Cause (Final Pnysician/ there scleratic disease or condition resulting in death) Medical Due to (or as a consequence of): scular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Dav Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 performed? Yes 2 No Hospital or Attending Physician; The 1 Yes 2 No 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No ၉ 1 Prinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D. completed filled in Medical 29a. Certifier 1 🕰 🖒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0053568 Som mas 500 upper Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thompson 32 Registrar's Signature State

O DHMH 17 Rev 7/2009

Registrar

			State of Maryland / Dep	partment of Health and Nertificate of Death	•	ne 011 01612
*	Physic /Medi		1. Decedent's Name (First, Middle, Last) PHYLLIS R. QUISENBERRY		2. Date of Death	Day Year 7:40 A
3	Exami		4a. Facility Name (If not institution, give street and number) SACRED HEART HOME, INC.	4b. City, Town, or Location of Death HYATTSVILLE	1	4c. County of Death RINCE GEORGES
i Sa	Funeral Director		5. Social Security Number 577-01-2817 G. Sex 1 M 2 X F 7. Age (In yrs. last birthda 102 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye August 30,	9. Birthplace (State or Foreig Country) 1908 Washington, D
	Maryland a-f show ffied at	tor	10a. State 10b. County 10c. City, Town or Maryland Prince George's Hyattsv			10d. Inside City Limit 1⊠Yes 2 □ N
	th with the 23a or 28a ist be noti	al Director	10e. Street and Number 5805 Queens Chapel Road	10f. Zip Code 20782	10g.	Citizen of What Country? USA
036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Standard Mexican, Puerton 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 horene. ene. than "natur he Medical E	Completed	(Specify only highest grade completed) (Gii Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) Cretary	king	nding Machine Company
land 2	should be filed and Mental Hygis marked other	To Be Co	17. Father's Name (First, Middle, Last) Edward Leonard Ransdell		ne (First, Middle, Main S	den Surname)
a,	nd 2 shouth and 27 is m			iling Address (Street and Number or Ru Mallory Square,		
			I M Bullat 2 Cleffiation 3 Themoval from State	rematory or other place)		entwood, Maryland
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	4	739 Baltimore Avenu lyattsville, MD 2078
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Amount of the disease or condition resulting in death) Myocardial Infarc Due to (or as a consequence of):		or respiratory arrest,	Approximate Interval Between Onset and Death 15 Months
/60,	Examiner be executed bhysician and bhysician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic H Lue to (or as a consequence of): Due to (or as a consequence of):	eart Disease		Years
O. BOX 68/	eath certifica attending phy for use as th	Physician/Medic	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown d. 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	23d. Date of delivery Month Day Year		
cords, P.	ician: The law requires that the de certificate has been signed by the ector, page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the Multiple Skin Cancer	underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknow
Ž	The law	Completed by			24a. Was an autopsy pertormed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
on or vital	ng Phys ter this neral dii	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work?	th Check onl one ome 5 Residence 28d. Describe how i	e 6 ⊡Other (Specify) njury occurred
	or Attenter death lirector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifie	29c. License number D 1 9 60 9		Date signed (Month, Day, Year)
	3		30. Name and a dress of person who completed cause of death (Item 23a) (Type		Gaithershi	irg. MD 20878

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 0- 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last Jan 14, Year **Physician** 2011 7:30 P M Angela Ouintela /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hillhaven Nursing and Rehab Center Adelphi AGETPIT

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Oct. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 578-56-9652 Cuba Director 86 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28a-f shov traumatic event, the Madical Examiner must be nuitified at 1 ☐ Yes 2 No Director Maryland Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8118 Felbrigg Hall Road 20769 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1X Yes 2 No Specify: Cuban Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vicente Quintela Isabele Hernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl Sarzo -nephew 8118 Felbrigg Hall Rd. Glenn Dale, Maryland 20769 other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or ance. ' 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/15/2011 Alexandria, Virginia Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Failure to Thrive months /Medical Due to (or as a consequence of): **Examiner** Senile dementia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 Other (specify) 4□Pregnant at time of death the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 2X No 1 Yes 25. Was case referred to medical examiner? 57 Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ihis in by the funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and the of certifier

31. Date filed (Month, Day seat) 2 4 20

22. Registrar's Signature

Museur

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter M. Schissler, M.D. 7500 Greenway Center Drive, #430 Greenbelt, Maryland 20770

D22780

29d. Date signed (Month, Day, Year)

January 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUNAUD RUSSELL 1818M Month 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMBRY LIENGRAL HOSP DLNEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Mooth Bay Year 959 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director HDHITCHELLVILLE Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? DEER RUN COURT 20721 1500 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) PEIVATE Elementary/Seconday (0-12) VICE PRESIDENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မှ RUSSELL 82 ELIZABETH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 DEER RUN COURT HITCHELLVILLE, 40 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State LAVEEL, MO 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL HEAL PK 21. Signature of Funeral Service Licer 22. Name and Addre Name and Address of Facility WASH, DC 20011 Upshur St NW 814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor: After this certificate has the funeral director, page 2 of autopsy yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 within 2 only one) 29c. License number 10050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Dr. 18101 MIS 32. Registrar's Signature JAN12 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 012011 Ruth Elizabeth Rankin 5:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1521 Amalfi Drive Westminster Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. 09/18/1935 Director 214-34-1499 75 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No MD Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1521 Amalfi Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 27 is marked other than "natural", traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 12 Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Cleveland Croft Naomi Orendorf permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Harman/daughter 1521 Amalfi Drive, Westminster, MD Method of Disposition

14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Zion Meth. Cemet. 1/5/2011 Frostburg, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel of Suneral Service License 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Endometrial Onset and Death Immediate Cause (Final Physician/ metastati disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CKD Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dan voya, MD 01-04-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 2111 Havove Hampetedd, MD 21074 PKE Lavores 31. Date filed (Month, Day, Year) 32/ Registrar's Signature State JAN 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:5.3AM Patricia Robinette Evelvn Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Funeral 1 □ M 2 □ **F** Months Nov 30 Director 213-40-2788 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important I fitem 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notified at 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12817 Winchester Road 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Thrasher Mary (Fazenbaker) Thrasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Donna Frankenberry P.O. Box 5121 daughte Cresaptown MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 1/16/201 4 Donation 5 Other (Specify) Cumberland MD 21. Signature of Funeral Jer 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myo Cardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last onery Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed evere Aorho attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Day Year signed by t I be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Af pmpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) anchar k Chenchu 2011 13 0006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 210 500 Willow Grooke Road, 31. Date filed (Month, Day, Year) Registrar's Signature State SAN 24 2011 Registrar

DHMH 17 Rev 7/2009

11-00	194
David	Rhinier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Cell	rtificate of Deat	th	Reg	No.			
Physicia	in/	Decedent's Name (First, Middle,Last)			Date of Death Month	Day Year	3. Time of Death		
edical Exami	ner	David Rhinier 4a. Facility Name (if not institution, give street and number)	T4b City	Town, or Location of Death	January 6, 2	4c. County of Deat			
		834 Wheeler School Road	White			Harford			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		er 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Bir Forei			
Director		175-54-9772 1XM 2_F 46	Yrs.	ns Days Hours Min	12/19/1	.964 Cd	puntry) PA		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Location				10d. Inside City Limits		
▶			st Earl				1 X Yes 2 No		
or 28a-f show	Director	10e. Street and Number	10f. Zip	Code	10g	. Citizen of What Cou	ntry?		
3 or 3		1494-0 Brierstown Road	17	7519		USA			
ceath with the Maryland or items 23a or 28a-f abo	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		ent of Hispanic Origin? (S fy Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,		
rer cea		1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2	X No specify:		Specify: Whi	te		
2 hours after natural",	d by	15. Decedent's Education (Specify only highest grade completed)		Occupation (Give kind of rking life, DO NOT use ret		6b. Kind of Business/	Industry		
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		iking ilie. DO NOT use tet	1160)				
-003 I withi giene.	Ē	17. Father's Name (First, Middle, Last)	machinist	18.Mother's Name	e (First, Middle, Ma	manufact	uring		
21215-0036 buld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	Be	Richard Mumma			ina Nies	•			
e, MD 21215-0036 and 2 should be filed within 72 Health and Mental Hygiene, item 27 is marked other than r traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Print)		(Street and Number or			e, Zip Code)		
ore, MD ss I and 2 sho of Health and If item 27 is her traumati	-	Jessica Rhinier / daughter 20a Method of Disposition	Place of Disposition (Nan	ew St., Lanca		20c. Location - City or	Town, State		
Baltimore, permit. Pages I are Department of Heal Important: If iten injury or other tra	-	Dulla: 2 2140 amation 3 Removal non State	crematory or other place)		17/0011	T *	D.		
altin nit. Pa artmer sortan	1	4 Donation 5 Other Specify: Cha. 21. Signature of Funeral Service Licepses	S. F. Snyder J 22. Name and	Jr. FH&Crem 1/ Address of FacilityChar	1//2011 1es F Snv	der Jr. Fune	ral Home &		
E E C B		falth M. HAT MO!	580 Cremator	y Inc., 3110 Li	titz Pike,	Lititz, PA	17543		
Physician //Medical		23 Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the mode of	of dying, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death) a Hypothermia Due to (or as a consequence of the condition resulting in death)	nn:				Death		
		Sequentially list conditions, b							
	ine	if any, leading to immediate cause. Enter Underlying Cause	f):						
ed sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or pure to the consequence or pure							
760, icate be executed physician and the burial - transit		d. X UNPENDED AMENDED 23a,27	,28a-f per	me g914 4-1.	5–11				
30x 68760, death certificate be to attending physici of tor use as the buri	- 1	IF FEMALE: 23c. If yes, outcome of preg	nancy			23d. Date of deliver	у		
lox 687 leath certific attending p	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of de	2 Fetal death eath 5 Other (Spec	3 Ectopic pregna	ancy	Month	Day Year		
. 58	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Spec						
s, P.O. irres that the signed by d be detached	b P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying	cause given in Part I.	i	2 No. 3 Pro	the cause of death?		
ts, Fauires duide sign					24a. Was an		utopsy findings available		
Vital Records ysician: The law requi	Completed				autopsy perform	prior to death?	completion of cause of		
Re i: The difficate or, page		25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	No 1 ✓ Y	es 2 No		
Vita ysician his cer directo	e Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2				esidence 6 🗸 Othe	er: Scene		
of Vital Reco ling Physician: The law After this certificate has funeral director, page 2 s.	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred exposed to			
Sion Attend death. sctor:	Gatio	Z Accident investigation	fd 1:55pm	1 Yes 2 X No	environ	mental col			
Division of Vital Records, and a Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the fameral director, page 2 should the fameral director, page 2 should the fameral director, page 2 should the fameral director.	Certification:	3 Suicide 6 Could not be determined (Specify) Found		, oπice building, etc.	or Town, Sta	te) 834 Whee	eler Schoole		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the fi		29a. Certifier 1 Certifying Physician: To the best of my knowled	lge, death occurred at the		due to the cause	(s) and manner as sta			
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier		c. License number		29d. Date signed (Me			
	ī	in I		O.C.M.E.		January 7, 2011			
		30. Name and address of person who completed cause of death (Item	1 23a)						
		Donna M. Vincenti, MD Assistant Medical Exar		timore Street, Baltir	more, MD 212	23			
St Regist		31. Date filed (Month, Day, Year) 32. Repistrar's Signate AN 2 4 2011	1. Saved	,					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per PHY C911 1/28/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#29d.PerPhys.PCC1-12-11cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **04** 3. Time of Death Physician/ Timothy W. Smith 22:12 р. м Medical Timothy 2011 Smith Jan. 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George Hospital Lanham Prince George 7. Age (In vrs. last hirthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 1 Year 1 ☑ M 2 □ F Months Days Hours Min. Director 40 Yrs 30 - 1970Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Q Yes 2 No PG Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2902 Brightseat RD <u>/#2</u>03 20706 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Wever Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ My Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Johnson+ Tow 12th Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sherman Bryant Gloria Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Smith/Mother 2902 Brightseat Rd. #203 Lanham, MD 20706 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Riverdale,MD 4 Donation 5 Other (Specify) Riverdale Cremtory D1_10_11 22. Name and Address of Facility Ronald Taylor II Funeral Hme. 21. Signature of Funeral Service Licensee 10583 Middleport In Whiteplains, MD 20695 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Severe Hente antiveacher 5 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner High cen'de mia Social trially list to differ sif any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Diaheter attending physician and for use as the burial-transit the Hospital or Attending Physician: The law equires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No t een signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tolcetiaci dosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2) 24 hours after deam. e Funeral Director: After this certificate haleted filled in by the funeral director, page performed cure tubular necrosis Yes 2 No 1 ☐ Yes 2 😾 No 25. Was case referred to medical examino?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 29c. License number Jan 3, 50 D004 3662 30. Name and address of person who completed-cause of death (Item 23a) (Type, Print) Cheverly, Maryland 20785 3001 Hospital Drive William Boyce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per med cert G911 1731/11 dk. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year >25 **Physician** DM Ernestine H. Smith JANUANY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Riverdale Crescent City Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 09 / 28 / 19 29 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months South Carolina 1 □ M 2 15 F Director 81 577 38 0814 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Experiment must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Mt. Rainer 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 4700 25th Street 20712 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Culinary Supervisor DC Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Harrington Carrie Gillespie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4700 25th St., Mt. Rainer, MD Barbara Smith White-Daughter Department of Health Important: If item 27 any injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 01/08/2011 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home LLC 21. Signature of Juneral Service 3005 12th St., NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arterioscherotic Candiovascular Diseas y servo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 Ho 5 ☐ Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hementia 24a. Was an has autopsy performe certificate Seizune Bisonder 2 **N**o 1 ∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural hin 24 hours after death.
the Funeral Director: A
mpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) **January 2, 2011** 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vernsbury Rd Hyattsville Mi MIS ORE 4203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAVID L. STRANGE JANUARY 08° 2011 1400P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 579-66-5168 1 🔀M 2 🗆 F Months Hours 61 1 20029 Day 5949 WASTINGTON, DC Director Usual Residence of Decedent 28a-f shov 10a State with the Maryland notified at 10b Counts 10c. City, Town or Location Director 10d. Inside City Limits MD PRINCE GEORGE LANHAM 1 X Yes 2 No 5 10e, Street and Numbe 10f. Zip Code Iral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 8809 KEEWATIN RD 20706 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' 1 Never Married 2 ☐ Married þ Black, White, etc. "natural", or 1 Yes 2 No If Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SECURITY OFFICER PRIVATE Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hw.
Important: If item 27 is maximply or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE STRANGE ပ MARY JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHANIKA HORTON/DAUGHTER 1485 HOWARD RD SE WASHINGTON, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place. 1-17-2011 SUITLAND, MD 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween MASSIVE CEREBRAL Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TYPOTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): SHOCK transit To the Hospital or Attending Physician: The law requires that the death certificate be executed CARDIOGENI and Due to (or as a consequence of) resulting in death) Last burial signed by the attending physician d be detached for use as the buria Physician/Medical NFARCTION YOCARDIAL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CORONARY ARTERY DISEASE Completed 1 Yes 2 No 3 Probably 4 Unknown been s ACUTE TURNLAR NECROSIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate PESPIRATORY Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mar ner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Inn 8, 2010 1/8/11 4366 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 WAM 6 to spiter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2:50 01 2011 Robert Leroy Swope Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Laurel Prince Georges 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 5. Social Security Number Sex **Funeral** 07 25 Month, Day, Year Days Hours Min. Country) Director 204-16-6303 86 Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince Georges Lanham 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 5624 Gregory Drive 20706 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. X Yes Yes, Give 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1946 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Electrician Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Robert Allen Swope Nellie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 5624 Gregory Drive Lanham, MD 20706 Lois M. Swope/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 1-07-2011 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit **Ca**chexia Due to (or as a consequence of): resulting in death) Last Physician/Medical Hypothyroidism Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death
Unknown 5 Other (specify) Yes 2 No ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🔲 Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 5 Pending 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0070459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Olubayo Oludara-Fadare 7245 <u>Hanover Parkway Ste B</u> Greenbelt, MD 20770 31. Date filed (Month, Day, Year, 32. Registrar's Signa State JAN 1 1 2011

Registrar

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	Funeral Director		5. Social Security N 577-58-3	3865	6. Sex	M 2□F	-	(In yrs. la:	st birthday, Yrs.	Month	der 1 Year s Days	If Under Hours	Min.	8. Date of B Jul 28	irth Da <i>y, Year</i>	43	9. Birth At La	place (State or Foreig anta, GA	
	rland f show	tor	Usual Residence of 10a. State	10b. County				10c. City	, Town or L		-	-						10d. Inside City Limits	
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Baltimore, Maryland 21215-0036	in 72 hou e. nan "natu Medical	Completed	(Spe	15. Decede ecify only high onday (0-12)	ent's Educ est grade	cation co <i>mpleted</i> College (1		-)	(Giv	e kind of v DO NOT u	se retired)	during mos				Kind of Bu			
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09	ite be executed hysician and he burial-transit	dical Examiner																	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23	c. If yes, ou 1 Live 4 Prec 9 Unk	Birth 2 gnant at	Petal	death 3	☐ Ectopi ☐ Other		ру				23d. Dai Mo	te of deliv	ery Day Year	
s, P.O.	es that the signed by	d by PI	Part II. Other signi	ficant conditi			death bu		lting in the	underlyin	g cause gi	ven in Part	: I.					he cause of death? bably 4 🗌 Unknow	
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/ital	sician: The law r certificate has b irector, page 2 s) Be	25. Was case referr examiner? 1 ☐ Yes 2	ed to medical X No		spital:		- 0 D I	ER/Outpati	t 2 🗆	Oth	er:	,-	1/		0 0 04	10:6	a	
of V	g Physer this leral di	e: To	27. Manner of Deat	h		28a. Date		, ;	28b. Time injury		28c. Injur	y at		ome 5 Res 28d. Describe				//	
Division of Vital	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pendi Invest 6 Could deterr	igation I not be	28e. Place	of Injur		me, farm, s	M treet, facto	work?						er or Rura	l Route Number,	
_	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 only one)	Certifyin	Examine g Nurse	r: On the ba	sis of exa	amination	and/or inve	stigation, , death oc	n my opinicurred at th	on, death o le ti me , dat	ccurred at	t the time, date	and place the cause	ce, and due e(s) and ma	e to the ca inner as s	use(s) and manner sta ated.	
	To the within 5 To the comple		29b. Signature and	title of certifie	F	dre	L			2	9c. Licenso	262	87		29d. D	ate signed	(Month,	Day, Year)	
R	_ 10		30. Name and addr	ress of person	Alho con	npleted caus	se of de	ath (Item :	23a) (Type,	Print) HAN	vire	31	d	107	C	llez	n Pa	ah mis	
	Sta Registr		31. Date filed (Mont	th, Day, Year)	he	32. F	Registrar	's Signatu	ure of					-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 7:50 P M Roberta Estelle Starner 2011 Jan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Summerville Westminster Carroll If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb. 15, 1 Country) 1 □ M 2 🔀 F 91 216-03-9159 **Director** Ï919 Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No MD Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 45 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Bankina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alver Elias Sprinkle permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Gladys Estelle Barrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Mann/daughter 4128 Turkeyfoot Road, Westminster, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc. 1/3/2011 Hampstead, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service-Licenses 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (er as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day signed by the a 1 Yes 2 D 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an was autopsy performed?
Yes 2 A cate has page 2 s or Attending Physician: The Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one assiti examiner? Hospital: Other: 2 100 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify, this 28a. Date of injury (Month, Day, Year) ieral Director: After th filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa WJL 8 cause of death (Item 23a) (Type, m 1) d 31 Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ January 1, 2011 5:40 p.M Bel1 Streets Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗷 F Months Hours 10/25/1945 Director 65 Florida <u> 262-76-7991</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral or items 23a USA 20653 21665 Galatea Street 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex gones. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Tobler Willie Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rutha Williams/Sister 329 West View Drive, Hampton, Virginia 23666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 02/01/2011 | Arlington, VA 4 Donation 5 Other (Specify) 21. Signature and Service Licensee

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cellulitis 36 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transit Exam Immuno Suppression 10 days that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 Unknown tor, After this certificate has been signed by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Profund Hypothermia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral Completed filled in the Funeral Completed filled in the filled Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗍 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mD D0066995 3 2011

Registrar
DHMH 17 Rev 7/2009

State

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LEUNTROJONN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKINTIDE

32 Registrar's Signature

ADEOM IN

31. Date filed (Month, Day,

JAN 06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Schneller Marlene Faye 5:40 a.m. Medical January 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Lexington Park Chesapeake Shores Nursing Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min 09/30/1936 Nebraska Director 74 507-36-4374 Usual Residence of Decedent Show 10a. State 10b. County 10d. Inside City Limits with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 X No Great Mills Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 45762 Dee Court 20634 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Filing Clerk Clerical Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 George W. Joiner Irene Faye Harrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Box 509, Leonardtown, MD 20650 Carolyn Y. Rice/Personal Rep P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it injury or 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 01/06/2011 Charlotte Hall, MD Signature of Edward N. H Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, any 20650 Hollywood Road, Leonardtown, MD M00052 22955 Jr. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and De Physician/ 0114 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Year been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Yes မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No hours after death uneral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) า 24 hours ล e **Funeral I** Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 з 🗌 only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) r person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 01 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 4:10 a.m. Frank Vincent Smith January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mary's Mechanicsville 25870 Hills Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 X M 2 - F Months Hours (Month, Day, Year) Maryrand Director 579-84-0990 1958 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Examiner must be notified at **Funeral Director** 1 Yes 2 X No Maryland St. Mary's Mechanicsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 0 23a 20659 United States 25870 Hills Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married 0 þ White permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural" Completed 3 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Ann Earman Frank Vincent Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $25870\ Hills\ Dr.,\ Mechanicsville,\ MD\ 20659$ 19a. Informant's Name/Relationship (Type, Print) Diane Smith/Wife 20a. Method of Disposition cemetery, crematory or other place) 01/11/2011
Trinity Memorial Gardens 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons and Death MoNiks Immediate Cause (Final CELL CANCER (LUNG METASTASE Physician/ 143/A11C LEFI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [only one) 29b. Signature and title of certifier 2011 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. MARY'S HOSPITAL, 25500 POINT LOCKOUT Rd, LEDNARDTOLON, MD-20650

State Registrar AMIR

31. Date filed (Month, Day, Year)

KHAN, MD

JAN U7

Registrar's Signat

		1- For State Registrar		ficate of	Death			Reg. No.		
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Las Benjamin Frank)	lin Vleck Stone					2, 2011	Year	3. Time of Death 1058 hrs
		4a. Facility Name (if not institution, given 18 Old New Windsor Road	d 2nd Floor		b. City, Town, o Westminst	ter		Carroll		
Funeral Director			7. Age (In yrs. last) M 2 F 28		If Under 1 Ye			Birth (MM/DD/Y 19/1982	YYY) 9. Birt Foreig Cor	thplace (State or untry) W.Va.
Varyland 28a-f shaw any d. at once.	or	Usual Residence of Decedent 10a. State Maryland Carroll		wn or Location	er					10d. Inside City Limits 1 X Yes 2 No
the Mary and 28a-	Director	10e. Street and Number 18 New Windsor	Road		10f. Zip Code 21157			10g. Citizen o United		
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a nr 28a-f shu or nther traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Ye		an, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)		White, etc. wት	can Indian, Black, nite
036 ithin 72 hours : ne. r than "natur! fedical Exami	Completed t	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life	e. DO NOT u	•		of Business/li ding s iler	
MD 21215-0036 12 should be filed within 77 th and Mental Hygiene. a 27 is marked other than umaric event, the Medical	8	17. Father's Name (First, Middle, Last) George E. Stone				Linda	Name (First, Middle Vleck		,	
MD 21 d 2 should lth and Me n 27 is ma numatic co	은	19a. Informant's Name/Relationship (T Linda Vleck Ston	me / mother	1009	Unionto	wn Roa		minster	, Mary	land 21158
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or nther traumatic event, the Medical.		20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other Specify: 21. Signal up of Funeral Service Lie of	Removal from State Carr	natory or other	cemation	n	Jan. 5, 2011 Eline Fu	Hamps		Town, State Maryland
Physician		23a. Part I. Enter the disease, or comp	M0107	72 934	4 South	Main	Street H	ampstea	id, Mai	ryland 2107
IMedical Examiner		failure. List only one cause on ear Immediate Cause (Final disease a.								Between Onset and Death
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
ted nsit	Examiner	Overla recently in death, East	Due to (or as a consequence of):					******		
760, Icate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED 23a,27,2	28a-f	per me	g912 2	?-2-11 vt			
O.O. Box 68760, that the death certificate be ned by the attending physici detached for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Feta	al death 3 er (Specify)	Ectopic p	pregnancy	23d. Dat Mon	te of delivery th D	ay Year
P.O. B res that the disigned by the be detached:	Ď	Part II. Other significant conditions		Iting in the un	derlying cause	given in Part				the cause of death?
Division of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certift him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending piptetely filled in by the funeral director, page 2 should be detached for use as	Completed						1 ✔ Ye	topsy rformed?		topsy findings available ompletion of cause of
Vital lysician: this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 ER	VOutpatient		Othor	Check only one) Nursing Home 5	Residence	6 Other	Scene
on of anding Ph th.	tion: T	27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	3b. Time of Inj		ury at Work? Yes 2 🗷 N	.	e how injury oc		medication
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate it completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 X Suicide 6 Could not be determined.	28e, Place of Injury - At home			building, etc.	28f. Location or Town	(Street and No	mber or Rur	ral Route Number, City
the Hospi	Medical C	29a. Certifier 1 Certifying Physicia	an: To the best of my knowledge, on the basis of examination and/o	death occurre or investigation	ed at the time, don, in my opinio	date and place n, death occu	e, and due to the ca	ause(s) and ma	nner as state	ed.
Paris G g	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date		ith, Day, Year)
wall		30. Name and defeat of person who of	THE SECOND SECON				Politimara MD	·	5, 2011	
	ate	Pamela E. Southall, MD 31. Date filed (Month, Day, Year)	Assistant Medical Examir 32. Registrar's Signature	par		ार आस्ट्रा,	Baltimore, MD	21223		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 7:00 A M Irene Winifred Samoisette January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Citizens Care & Rehab Center Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year Country) 1 M 2 🖳 95 **Director** 015-01-6190 1915 Dec Massachusetts Usual Residence of Decedent show 10a. State with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Frederick Frederick 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 21703 5303 Hever Way United States · death · Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. White Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked should be George Brindle Florence Girrior and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorene Pregenzer / Daughter 5303 Hever Way, Frederick, MD 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) Memorial Gardens Frederick, Maryland Signature of Fundal Privice I censes Resthaven Funeral Services, Skkot Cody P.A MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death v one cause on each line Physician ement disease or condition resulting in death) Medical Due to (or as a consultience of) Examiner Sequentially list conditions, if any, leading to immediate cause. Finter Underlying Examiner roidism burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a attending physician Physician/Medical that the death certificate be Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 **N**0 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and fixle of certific 29c, License number 29d, Date signed (Month, Dav. Year) 6,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) frederick 300 MD West

State Registrar 31. Date filed (Month, Day, Year)

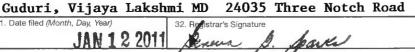
32. Registrar's Signature

to a search

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Smith 2011 5:54 AM Michael Dennis January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Callaway Hospice House If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Min October 20, 1957 District of Columbia 1 X M 2 ... F 217-72-9908 5 3 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director Maryland St. Mary's Mechanics ville 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 26939 Bosse Drive 20659 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 - Widowed 4 - Divorced White Year or Dates is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beverage Company Salesman Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Lacey Clinton Wynn Smith Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 26939 Bosse Drive Mechanicsville, MD David M. Smith Brother 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State January Leonardtown, Maryland 4 Donation 5 Other (Specify) 2011 Charles Memorial Gardens 15. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 clear 23a. Part \. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) End STORP Medical Due to (or as a consequence of): **Examiner** stare Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or linjury IteDatic attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical OCSOPHAG Pal Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate 2 1 Yes ☐ Yes
 the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 6 Pother Specifice House 2 No Other: 1 Tyes မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registra 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Hollywood, Maryland 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 2, 2011 Austria Ashleen Smith 0221 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Adelphi Heartland of Adelphi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/1913 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. Days 1□ M 21 F Months Hours North Carolina 579-30-5967 97 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1XYes 2 No Hyattsville Maryland | Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20784 USA 4800 67th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse/CNA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anniebelle J. Johnston Dowd Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 910 17th Street, NW #800, Washington DC 20006 Robert Bunn (Conservator) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Macedonia Church Cem. 1/11/2011 Mt. Holly, NC 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 mo Day Year 5 Other (specify) 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Descaso 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 6 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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death

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Baltimore, Maryland 21215-0036

Box 68760,

P.O. 1

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Physician/Medical Examiner ð Completed Be Certification: To

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

law requires that the death certificate be executed Records, spital or Attendi nours after death. neral Director: A death. 24 hours

State Registrar 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🛮 🖢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pd # Z16. ROCKINIK, MD 20852

29c. License number

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

31. Date filed Year!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#8.PerFHPGC1-13-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Vincent Smith 6:42 2011 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct. 9. Birthplace (State or Foreign **Funeral** Months 1 ፟ M 2 □ F 229-54-8789 Hours Min. (Month. 69 **Director** Coalwood, 20**,**1941 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731 S Street 20009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Ith and Mental Hygien

27 is marked other the traumatic event, the Personal Management Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 William A. Smith Mary Barlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i Manuel G. Smith / Brother P.O. Box 1781, Junction City, KS 66441 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 1/4/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue reano H Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIOSCIENTIC CARDIOVISCO IM disease or condition resulting in death) -en Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the bunal by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Human Immunode ficiency Virus / AIDS Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Chronic Obstructive Lung Disease Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed?

1 Yes 2 N this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Duicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 6 2011

32. Registrar

4203 QUEENSOOR

2. Date of Death

3. Time of Death

	1 - For State Registrar
	1. Decedent's Name (First, Middle, Last)
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25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4	Heco	0 5 0	omplet									aut per	topsy rformeg?	prio	or to co	mpletion of	s availabl cause of			
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Ayman Aktad 7600 Osler Dr.#411 lowson ND 21204	,			•	1		/	1	1	>4	12/31	0		1/1	7/	//				
State 31. Date filled (Month, Day, Year) 32. Registrar's Signature				30. Name and address of p	person who co	mpleted cause o	death (Ite	23a) Type.	Print)	1	a -11-411	1 14.11	0 64 14	m	-	1/2/	,			
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DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. JOSEPH ELMER SNELL SR. 2011 9:19P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHARLES 2135 CRAIN HIGHWAY WALDORF Social Security Number Birthplace (State or Foreign Country) 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 227-14-1666 1 🔀 M 2 🗆 F 1(Montho Pay, 1Year) 2 88 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2135 CRAIN HWY. 20601 U.S.A. permit. Page I and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event the Marier I. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No ARMY
If Yes, Give WWTT 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK WWII 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) EMBASSY DAIRY DAIRYMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HAYES WESLEY SNELL ETTA DeHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6820 WISCONSIN AVE. CHEVY CHASE, MD. 20815
#2003 JOSEPH E.SNELL, JR.-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from Sta cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 1-22-11 M00479 21. Signature of Funeral Service Licenses FUNERAL SERVICE, P.A. MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician + schenic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burlal-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 2 No one reneral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
 Funeral Director: After this certificate has k autopsy
performed?

Yes 2 No. 2 🗆 No 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 ☐ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of <u>ë</u> 28c. Injury at 28d. Describe how injury occurred 1 Natura! work?
1 Yes 2 No injury 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number Jan. 18. 2011 ne and address of person who completed cause of death (Item 23a) (Type, Print) 20646 WINESup AL 11655 Lu 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 12:40 A M Noelle Lacey January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In vrs. last birthdav) 8. Date of Birth 1 🗆 M 2 💢 F Hours (Month, Day, Year) 07/02/1987 **Director** 219-17-4521 23 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No St. Mary's Lexington Park Marvland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46860 Hilton Drive, Apt 511 20653 II S A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene. 1 Yes 2XXNo Specify. Specify: White Completed 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any july or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Veronica Ann Heinlein Herman Κ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Lee Smith/Sister Walnut St., Apt. 3, Lemoyne, PA 17043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem. 01/13/2011 Charlotte Hall, MD 22. Name and Address of Facility Frinstield-Echols F.H., P.A. 21. Signature of Funeral Service Licenses MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician. disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner HRONIC CONSTIPATION Sequentially list conditions Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events DYSTROPHY The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last ARDIOMYOPATHY Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has be lirector, page 2 sl autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \(\text{Yes} 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death

2 DHMH 17 Rev 7/2009

State Registrar ST. MARY'S

Hospital Leonardtown mo

and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN.16 Pay 2011 Physician ROBERT EDWARD SIMPSON 7:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA GENESIS LA PLATA CENTER 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MD^{Country} 1 ☑ M 2 □ F 81 213-30-2660 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at LA PLATA MD. CHARLES Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 MAGNOLIA DRIVE 20646 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Specify: WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) SO.MD. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRIC CO. SERVICE WRITER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KATHERINE LUCILE DAVIS EDWARD EARL SIMPSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LA PLATA, MD. 20646 MAURINE SIMPSON-SPOUSE 111 MADISON ST. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition ST. MARY S CEMETERY 1-20-11 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEWPORT, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Signature of Funeral Service Licenses 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure to thrive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed physician and the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical certificate as attending properties for use as IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year P.O. I TYPS 2 No 9 Unknown à signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? as 2 s autopsy page perform certificate 2 1 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Natural
2 Accident within 24 hours after deau..

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Suik

70090

Annapolis, MD

lam

Fidewater

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Colony Dr.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend 19b per FH G911 1/24/11 dk
State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month SCHMINT 055 M Physician/ ARBARA 2011 . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner HARFER REZ COMPA AIR MARTISM PREA CHOSAIEAKE 8. Date of Birth If Under 24 Hrs. 9 Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Country) Maryland (Month, 937, Year) Months Days Hours Min. 215-42-2160 69 9 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Jarrettsville MD. Harford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 21084 United States 1440 North Bend Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>م</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: Specify. Yes, Give 3 Widowed 4 Divorced White "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Harford County Elementary/Seconday (0-12) marked other than College (1-4 or 5+) permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Board of Education Assistant Instructional 1½ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Peyton Elizabeth E. Stone Oliver Arthur 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Prin(Husband) 1440 Notth Bend Rd. Jarrettsville, MD. Curtis J. Schmidt Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Date 21, 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens 2011 Fallston, Maryland Highview Mem. 4 Donation 5 Other (Specify) Signatury of Funeral Service Lidensee E.G. Kurtz & Son Funeral 22. Name and Address of Facility Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PRUB ABLE Physician disease or condition resulting in death) Medical Examiner アクシアから Sequentially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy
5 Other (specify) Month Day Year ę Pregnant at time of death 9 Unknown s been signed by the should be detached 9 Unknown Schmidt, Barbaram 8 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b page 2 st autopsy death? 1 Yes 2 No To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ရှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date sighed (Month, Dally, Year) 29b. Signature and title of certifier 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Mr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ler 3:10 BM ayman anuara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Futurecare Pinview Nursing Home Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2🛣 Days Hours Min. (Month, Day, Year Aug. 22. 1920 Virginia Director 579-14-2807 90 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ham material. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Charles Waldorf 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2510 Lisa Drive 20601 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ William F. Hoffman Mary Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 Fountain Drive, Unit 1007, Reston, VA 20190 JoAnn Lashley/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 01/18/2011 4 Donation 5 Other (Specify) Maryland Veterans Cem Cheltenham, MD 22. Name and Address of Facility ${\tt Brinsfield-Echols}$ F.H., P.A., 21. Signature of Funeral Service Licens (Meb) MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tro Kt disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HAIVAL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has performed? death? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death, neral Director: After the illed in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State within 24 hours at To the Funeral D completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avenue

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

IAN U 7 2011

22. Registrar's Signature

		1.	For State Registrar	State of Maryland		artment of F		-	giene Reg. No.	0	01638	l I
Œ	-		Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death	
	Physicia		LEO BERNARD TO	OPPER				Janua	ry 1	, 2011	8:35 A	М
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	1	4c. C	County of Death		
1			Copper Ridge			Syke	sville			arroll		
	Funeral		Copper Ridge 5. Social Security Number 6. S	Gex 7. Age (In yrs. It		If Under Year Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)	Coun		
	Director		213-42-1733 Superior	65	Yrs.			June :	29,		rederick aryland	,
and	w t		10a. State 10b. County	10c. City	, Town or Lo	cation					0d. Inside City Limits	3
Mary	f sho	호	Maryland Fred	erick En	nmits	bura					¹√ Yes 2 No)
the	r 28a	rec	10e. Street and Number	CIICA	mi L C D	10f. Zip Code			10g. Citize	en of What Coun	try?	_
h with	23a o st be	<u>=</u>	28 Federal Ave	nue		217	27	ſ	Unit	ed Stat	ces	
5-0036 72 hours after death with the Maryland	ems (Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. 1	Was Decedent of H	lispanic Origin? (Span. Mexican, Puert	pecify Yes or No o Rican, etc.)	. 1	4. Race - Americ Black, White,		
affe	or It		1 ☐ Never Married 2☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give X	l	1 □ Yes 2√□ No	Specify:	,		Specify:		
3-UUSD 72 hours af	ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Wni		
	"nat edica	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	160. KIN	d of Business/Ind	ustry	
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iled A	Hygi other ent, t	ပိ	17. Father's Name (First, Middle, Last		VIC	e iiesi	18. Mother's Nan	ne (First, Middle,				
yland ould be file	ked c	To B	Leo Topper				Anne M	ae Gel	wick	s		
	t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, <u>the Medical Examiner must be notified</u> at	1	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street	and Number or Ru	ıral Route Numb	er, City or	Town, State, Zip	Code)	
, Ma and 2 s	lealth am 27 is		Mary L. Topper	/Wife	28 F	ederal	Ave, Em	mitsbu	rg,	MD 2	1727	
or e ,	Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other pla	ce)	Date		ation - City or To	wn, State	
	ant: I	- 3	1 ☐ Burial 2 反 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Speci</i>	Soi	uth		11/2	/2011	Sy	kesvil	le, MD	
	port port y Inj		21. Signature of Funeral Service Lice	nsee		Cremat		Eurose	1 110	m o		
п	LÕ E TO TO		23a. Part1. Enter the disease, or com	Lupsolul	- M	lyers-Du	rboraw ain Str	eet. E	mmit	me sbur a	MD 2172	7
			Shock, or heart failure. List only	one cause on each line							Approximate Interval Between Onset and Death	
	hysician		Immediate Cause (Final disease or condition	a Afreruscia	wohl	card	10VG SCV	(as	[] (]	ease	Onset and Death	
611	Medical xaminer		resulting in death)	Due to (or as a consequ	uence of):							
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pet	ısit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	acrice ory.							
J SXBCU	sician and burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					-		
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D Tilling	g physias the	edic		-u.								
BOX	attending ph	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					2	3d. Date of deliv	ery	
D	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	у			Month	Day Year	
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,	been signed by the should be detached	by F	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	inderlying cause gi	ven in Part I.				he cause of death?	
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	ertific ector,	Be (25. Was case referred to medical examiner?	112-1		To:		ath (Check only	one)			
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		0.0			28b. Time of		In/ at	28d. Describe	now injury			
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DIVISION OF VITAL To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certification of the funeral director, it is completely filled in by the funeral director, it	edical	1 Natural 5 Pending investigation investigation of Could not the determined determined 29a. Certifier 29a. Certifier 29a. Medical Execution of Could not the determined determined determined 29a. Certifier 29a. Certif	(Month, Day Year) 28e. Place of injury - At he building, etc. (Specification) Physician: To the best of my known in the busis of examinary.	Injury ome, farm, st	M 1 Creet, factory, office th occurred at the investigation, in my	Yes 2 No	City or To	e cause(s)	d Number or Rur) and manner as place, and due	stated. to the cause(s)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 3:30 a Thompson January Drury Miriam Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Hollvwood 43830 Thompson Farm Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 06/02/191 Days Hours Min. 1 M 2XX Yrs Maryland Director 99 214-48-7569 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland 넒 Director ral", or items 23a or 28a-f sl Examiner must be notified 1 Yes 2 No St. Mary's Hollywood Maryland Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20636 43830 Thompson Farm Lane should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Saunders Joseph Drury Lillie I and 2 should b f Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24814 Sotterley Road, Hollywood, MD 20636 Frances M. Thompson/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 01/15/2010 Hollywood, MD St. John's Catholic 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature funerals, the representation of the rest 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 и00052 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lime Immediate Cause (Final disease or condition Ph_sician/ 13 Medical resulting in death) Due (or as a consequence of) Examiner Gequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No Month Day ξ Pregnant at time of death Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes this certificate Yes 24 hours after death.

Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \sum Yes Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Dath 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural М Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the I within 2 only one) 29d. Daye signed (Month, Day, Year) 29b. Signature and title of certi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar C.

31. Date file (Mo

Boyd,

M.D

Registrar's Signaty

41680 Miss Bessie Dr., Leonardtown, MD 20650

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

III W. ITIGH ST Registrar's Signature

KHAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Januarv РМ Shirley Lorriane Umbarger 1725 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Laurelwood Care Center 5. Social Security Number 8. Date of Birth (Month, Day, March 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 1<u>934</u> Months Days Hours Min. Virginia Director Yrs 201-26-8259 Usual Residence of Decedent ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Laurel Drive 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Specify. 3 Widowed 4 X Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>In Her Own Home</u> is marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other trainmets. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harvey William Bise Minnie Lee Havens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Juba/Sister 92 Watson Way, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January 21, 2011 Ridgedale Cemetery Rich Valley, VA 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on wach line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. (Disease or linjury Due to for ea a consequence the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate?

In hy the funeral director, pag performe 1 🗆 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **Z**No 2 Other 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number within 24 hours a To the Funeral L Medical 29a Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 24 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2011 3:49 P M January Ronald Winston Vaden Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death North Brentwood Prince Georges 4530 - 41st Avenue 5. Social Security Number 8. Date of Birth (Month, Day, Ye June 8, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days 1 XM 2 F Washington, D.C. Director 66 Yrs. 577-60-7687 Ĩ944 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Maryland Prince Georges North Brentwood 1X Yes 2 ☐ No 10e. Street and Number 5 10f. Zip Code 10g, Citizen of What Country? items 23a 4530 - 41st Avenue United States 20722 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Specify: **Black** 3 Widowed 4 X Divorced Year or Dates.Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Automobile other than Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineer Dealers Association llth grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Susan Lavon McNeil John Humphrey Vaden f item 27 is marked r other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 4001 Bali Court; Woodbridge, Virginia 22192 Ronald Richard Wright (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or otl Jan. 14, 2011 X Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Not Stated Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Diabetes Mellitus Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Prostate Cancer autopsy performed? Yes 2 No Pancreatitis 2 🗌 No 1 Tyes Yes To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD# 34028 January 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael P. Villaroman, M.D. VAMC, 50 Irving St. NW Washington, DC 20422 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05^{Day} $\overset{\text{Month}}{01}$ Physician/ 2011 4:26 A Jesse C. White Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1X M 2 F Hours Min 05/10/1929 South Carolina Director 250-40-1309 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Prince George's Fort Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 6801 Bock Road 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2x No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Smithsonian Museum Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Coleman item 27 is marked ၀ Mack White Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Huntland Road Temple Hills, MD 20748 John Moore/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Chandler Cemetery 01/18/2011 Lynchburg, SC 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final HISART Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consumence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Yea Pregnant at time of death by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ MULTIPLE MYELOMA 1 Yes 2 No 3 Probably 4 Unknown Completed peen DISEASE 24b. Were autopsy findings available prior to completion of cause of death? KIDNEY END STAGE 24a. Was an certificate has autopsy performed Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖭 No ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hou To the Fune completed fil 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 115/2011 MID 00064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State JAN 1 1 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Paul Joseph Weber 3:50 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₺ M 2 🗆 F Months Days Hours Min. (Month, Day, Y 192-28-1283 Director 73 Pittsburgh, PA Nov Usual Residence of Decedent shov 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified. Prince George's **Bladensburg** MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20710 USA 5443 Varnum Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 K No Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Education Systems Computer Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .nt. Page 1 and 2 shv.
.ant of Health and Ms.
.tem 27 is marked v. ည Veronica Sammon Edward C. Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5443 Varnum St., Bladensburg, MD Jeanne G. Weber - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/11/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Lincoln Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 levo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Respiratory failure Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Metastatic colon cancer Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Pregnant at time of death 2 🗌 No the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 2 X No Hospice ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 115 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 1/7/2011 D47259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9811 Mallard Dr, #205, Laurel, MD 20708 Lipishree Nayak, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2011

Registrar

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Maryland

Baltimore,

P.0.

of Vital Records,

Division

State Registrar Syed S.

31. Date filed (Month, Day, Year)

Hosain MD

JAN 0 4 2011

DHMH 17 Rev 1/200

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32. Registrar's Signature

447 East Main Street, Westminster, MD

Please Type or Print In Black Indelible Ink. Ensure All Coples Are Legible. 11-00214 State of Maryland / Department of Health and Mental Hygiene Matthew John Willquette 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Time of Death Physician/ Month MATTHEW JOHN WILLIQUETTE Month Day January 7, 2011 2240 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Mount Airy Eastbound I-70 East of Exit 68 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 12/10/1988 Country) Director MD 22 1 X M 2 F 213-23-9652 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a. State 10b. County 1 Yes 2 No s 23a or 28a-f show e notified at once. DAYTON 28a-f show HOWARD t. Pages I and 2 should be filed within 72 hours after death with the Maryland memor of Health and Mental Hygiene.

Tant: If item 27 is marked niher than "natural", nr items 23a or 28a-f sho or other traumatic event, the Medical Examinor must be active. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21036 5220 KALMIA DRIVE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes WHITE 1 Yes 2 No specify: Specify 4 Divorced If Yes, Give Year 3 Widowed 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) LANDSCAPE SUPERVISOR LANDSCAPING 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DEBRA ANN WRAY KEITH ALLAN WILLIQUETTE Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5220 KALMIA DR., DAYTON, MD KEITH WILLIQUETTE/FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CEMETERY 01/11/2011 SUNSHINE, MD CARMEL 4 Donation 5 Other Specify 22 Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months?

Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

In the Funeral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

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Completed

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Certification:

Medical

State

Registrar

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day) Year)

Melyante

1 Yes 2 No 9 Unknown 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause	
	1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 Yes 2 No
26. YEAR GERS TOTALING TO INTOCION	e of Death (Check only one)
examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other: Scene
	ury at Work? 28d. Describe how injury occurred
	Yes 2 ✓ No Driver auto fixed object collision
2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Interstate/Express	building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Eastbound I-70 East of Exit 68, Mount Airy, MD
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, cone) Medical Examiner: On the basis of examination and/or investigation, in my opinio	late and place, and due to the cause(s) and manner as stated. n, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

Kneur

30. Name and address of person who completed cause of death (Item 23a)

OCME

29d. Date signed (Month, Day, Year)

January 8, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 Day 2011 Watkins 6:00 PM Reva Mae January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1926 6. Sex 7, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 84 Mary land Director 215-20-3702 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura!"
any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 U.S.A. 333 Russell Avenue - Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Brown Frances Lee Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel C. Watkins - Son 11901 Wonder Court, Monrovia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Senation 5 ☐ Other (Specify) Wesley Grove Cemetery 1/12/2011 Gaithersburg, Maryland 21. Signature of Puneral Service License 22. Name and Address of Facility.
Molesworth-Williams P.A., Funeral Home Trest 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ stive heart failure disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day be detached g Unknown P.0. à 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No esmha 2 🗆 No 25. Was ase referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certificate: To | 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL 14. ROBORI 3/RSCHBACH, US

Year

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROGER MAXWELL WZLUZAMS 5:00A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST MARY'S HOSPETAL LEONARROWN ST MARY'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day,) October 4, 7. Age (In vrs. last birthday) Funeral 1 ፟ M 2 ☐ F Year) 1936 Hours Director 226-46-3405 74 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No St. Mary's Maryland Lexington Park 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 21715 North Essex Drive 20653 IISA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married Yes 2 No Yes, Give þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mechanic Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Williams Mary Alice Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardelia V. Williams/ Wife 21715 North Essex Drive Lexington Park, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 15. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, Maryland 20650 21. Signature of Funeral Service Licenses P.O. Box 270 Leonardtown, Maryland Han 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MULTE - ORGAN SYSTEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): PNEUMONTA ASPERATION Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical HERPES ENCEPHALTIZS the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 □ No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, DIALKIZS DEFENDANT RENM FATHURE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes Vital å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo ျင 1 Tyes 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hin 24 hours a the Funeral D npleted filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title certifier 0

State Registrar 25500 POINT LOUGULT FORD, LEDNARATOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

B. RUBERT GEBSON MO

11-00141 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adonis Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death **Medical Examiner** 1913 hrs Adonus H. Wilson Adonis H. Wilson January 4, ŽÕ11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Fort Washington Hospital Fort Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Months Days Hours Director 218-85-7011 Country) XX M 2 F Yrs 08-30-2009 Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d Inside City Limits Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Montal Hygiene.
In item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Yes 2 No Prince Georges Fort Washington Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2700 Kingsway Road 20744 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 XX Never Married 2XX No Yes 4 Divorced If Yes, Give Year Specify: Black 3 Widowed 1 Yes 2 XXNo specify: 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rayquan Wilson Anneke Dowdell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayquan Wilson / Father 2700 Kingsway Road, Fort Washington MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ressurection Cemetery Clinton 4 Donation 5 Other Specify 1-15-2011 21 Signature of Funeral Service 22. Name and Address of Facility ^y J.B. Jenkins Funeral Home Road Landover Marylan<u>d</u> 20 7474 Landover Landover Maryland 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Sudden Unexplained Death In Infancy Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last g physician and the burial - transit the Hospital or Attending Physician: The law requires that the death certificate be executed Ca x AMENDED 1,23a,27,28a-f per me g913 3-28-11 vt X UNPENDED Physician/Med Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the ned by the attending detached for use as # Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? ✓ Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) director, Be examiner? Hospital: Other Nursing Home 5 Residence 6 Other this Inpatient 2 PER/Outpatient 3 DOA 1 Yes After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Natural 5 Pending 1 Yes 2X No in by the 1-4-11 fd 6:25pm unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2700 Kingsway Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide 6 X Could not be (Specify) residence Homicide Washington,

within 24 hours after death.

29a. Certifier 1

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

2011

OCME January 6, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrads Signat

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrate Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 01 $03:22^{a_M}$ Physician/ 2011 Carlota R. Zanders Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1 ☐ M 2 🏝 F Funeral Days Months Hours Min (Month, Day, Year) 11/07/1922 Yrs San Diego. 88 **Director** 562-26-6184 Usual Residence of Deceden 10d. Inside City Limits 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Prince Georges Ft. Washington 10g. Citizen of What Country? 10e. Street and Number Funeral 20744 12021 Livingston Road Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify Hispanic If Yes, Give 3 Widowed 4 Divorced Completed Mexican Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done (life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Private Residential Domestic Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zefferino Romero <u>Micaela Lopez</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13102 Larkhall Circle Ft. Washington, MD 20744 Angelina Gibson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Lincoln Crematory 01/11/2011 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licenses Horra Montgomex Bladensburg Road Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine evenereo S _uential | list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence oi) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 2 🗌 No Yes 2 No 1 Yes After this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 / No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To Manus of Death Date of injury (Month, Day, Year) 28b. Time of filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 24 only one ertifier 29b. Signature 201 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person why 2 MM 20735 31. Date filed (Morth, Day, Year)

JAN 1 1 2011 Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month ALHUSSAIN **Physician** 15:09 PM THMAN january 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 19 Apr. 6,1991 Saudi Arabia Director UNK Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No Directo Examiner must be notified Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be no 1001 Aliceanna Street, Apt. Saudi Arabia 21202 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: ş Specify: Arabian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 never employed student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mohammed Alhussain Alhossain Hussa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Aliceanna St. Apt.904, Baltimore, Maryland Mohammed Alhussain (father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jan.26,2011 Saudia Arabia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Witzke Funeral Homes. Inc. 5555 Twin Knolls Rd. Columbia, Maryland 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No certificate 2 🗌 No Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 1/ Inpatient 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 28b. Time of 28c. 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation Injury s after death. 1 🗌 Yes 2 □ No , the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (check only and manner stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00194 me and address of person who completed cause of death (Item 23a) (Type, Print) KO 600 North Wolfe St, Baltimore, MD, 21287 owe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 20 Physician/ Month 4:03P Borgmann Robert JANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner timure City irs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 24 Hrs. Funeral 1 🔀 M 2 🗆 F Months Hours Min ^(ear) 1955 June 10, Director 214-62-3317 Maryland rert Borgmann Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Baltimore Owings Mills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Cedarmere Road 21117 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 K Married 'natural", or If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White Fuelwh 45 Ko Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Sa1e Tire Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton Sutherland Borgmann Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Borgmann 124 Cedarmere Road Owings Mills, MD 21117 injury or other Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/25/2011 Westminster, MD Meadowbranch Cemetery! 21. Signature of Funeral Service Literases 11824 Reisterstown Road 22, Name and Address of Facility 21136 ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the enterest as a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Intracrania Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hupertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 4 No 1 Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{P Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu М 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

only one 29b. Signature

SURAJIT

DHMH 17 Rev 7/2009

Resident Physician

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAHA

Pay Year) 2011

IM-D.

29c. License number

RES-000

Sinai Hospital of Baltimore

29d Date signed (Month, Day, Year)

JANUARY 20,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ BEPNIER NORMAN 2210 PM Jan 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Madial Conter 0-Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) Sept. 26, 1932 Months Hours Min 1 K M 2 D F 021-22-6395 Director 78 Connecticut Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2K No MD Howard Columbia 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9111 Gracious End Ct., #102 21046 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

12 Yes 2 No 1952-Black White etc. "natural", or 1 Never Married 2 Married <u>م</u> Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: white Completed 3 ₭ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Craftshop Supervisor GSA permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Louis Bernier Beatrice Doucette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane E. Bernier/ Daughter 9050 Gracious End Ct., #203, Columbia, MD 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State January West Arundel Crem. Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Donaldson Funeral Home, P.A. . Signature of Funeral Service Licensee M01053 313 Talbott Ave., Laurel, MD Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 313 Talbott Ave., Laurel, MD 20707 Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit nfector Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sapsis 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? his certificate has bu I director, page 2 sh 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ဂ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 🔲 Yes 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19745 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 och 9 Greene St. Battimore

10+1. State

Registrar DHMH 17 Rev 7/2009 22

32. Regiştrar's Signature

Scott

26

JAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:56 PM Januar Ronald Parker Biggs 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospita George rince Laure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 25 1935 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1X**X M 2 □ F Months Days Hours Indiana Director 307-34-1352 Usual Residence of Decedent 28a-f shov at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Anne Arundel Laurel 20 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 437 Old Line Avenue 20724 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 ρ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify. White Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) filed within al Hygiene. 12th Intelligence other Analyst Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental f is marked o မ Ellis Biggs Nora Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health if item 27 i permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Old Line Avenue, Laurel, MD Sheila Biggs/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/21/2011 Meadowridge Mem. Pk Elkridge, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Se quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) -transit executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 death? certificate 2 No Division of Vital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 - No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death.

Ineral Director: After this
of filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital hin 24 hours a the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ! within 2 To the 29b. Signature and tle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

JAN

7300

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 30 per dvr g911 1-26-11 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 19, 2011 2136 Kenneth Ted Bailey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford Under 1 Year | If Under 24 Hrs. onths Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F Yrs. 09/27/1944 West Virginia Director 66 233-68-4990 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Exertines must be notified at ¥XYes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 611 Plater Street 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 tree trimmer landscaping other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be nd Mental marked o . Pages 1 and 2 should be treent of Health and Ments tant: if item 27 is marked Ted Bailey Ethel Watts ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth Bailey (son) 611 Plater St., Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: if ite any injury or ot once 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Company 01/21/2011 West Chester, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): CIRRHOSIS Examiner AICOHOLIC YMRI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) sate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Cobably 4 ☐ Unknown TIBRILLA TON ATRIAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ 10 24a. Was an autopsy performed 1 Yes 2 or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/201 100 56 296 30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood St. #206 Bel Air, Md. 21014 Jason M. Birnbaum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ann S. park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Sandra A. 2. Date of Death 3. Time of Death Burl Physician/ DEN her 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Med Center Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 48 vrs cial Security Number 217-68-3118 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours Min 12/19/62 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. Count 10d. Inside City Limits the Maryland 10c. City, Town or Location Director MD N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral 1140 Cooksie Street with 21230 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Yes Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward G. Burl Catherine Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Maylor 1140 Cooksie Street, Baltimore MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Ardent Crematory 1/22/11 1 Burial 2XXCremation 3 Removal from State Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor Name and Address of Facility Darles L. Stevens Funeral Home, 501 East Fort Avenue, Baltimore Doda Ρ. 1)10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e in line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying executed Cause (Disease or linjury d that initiated events resulting in death) Last Due to (or as a consequence of): the burialsigned by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Yes 1 ☐ Yes 2 to 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Division of Vital Records, 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy completed filled in by the funeral director, page 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Deat 28a 28b. Time of 28c. Injury at work? 1 🗋 Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 No Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) title of certifie 29b. Signature a 29d. Date signed (Month, Day, Year) 20 20 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) mi 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Custis 01 201 7:40n Estelle 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Nursing Home Baltimore 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral Min. Months Hours 1 □ M 2**x**□ F Country) Director 214-26-7568 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral 4100 Groveland Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade NA Seamstress Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Alex Jolly Irene Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 4100 Groveland Ave, Gwendolyn Mae-Granddaughter Baltimore, Md 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site /22/2011 Baltimore, md 21. Signitule 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, of Funeral Service Licer Baltimore, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death heck only one) examiner? Other 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific D0069314 Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Rd Parpulle MD 21234

Registrar
DHMH 17 Rev 7/2009

State

JAN 26

Physici /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar	- t 4)		Cei	rtificate c	Deam	2. Date of De	Reg. N	0.	3. Time of Death		
ın	Decedent's Name (First, Middle	,	h o se				Month	D	ay Year			
al	Avery Bernon						Januar			0:23 p		
er	4a. Facility Name (If not institutio	n, give street and nu	mber)			n, or Location of Dear	th		c. County of Dea	th		
	Lorien Nursing				Columb If Under 1 Ye		0 D.1. (B)		loward			
	5. Social Security Number 577-24-8756	6. Sex 1 [X :M 2 ☐ F	7. Age (In yrs. I	90 Yrs.	Months Da			a <i>y, Ye</i> a	r) Co	thplace (State or Fore		
ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Lim		
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ect	MD Howa 10e. Street and Number	Iu	10010	IIIDIa	10f. Zip Coo			10a. C	itizen of What Co	ountry?		
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eral	7379 Swan Poin		edent Ever in U.	C 12		of Hispanio Origin? (Specify Vec or N		14. Race - Ame	erican Indian		
Funeral Director	11. Marital Status	Armed F	orces?		If Yes, specify (of Hispanic Origin? (Suban, Mexican, Pue	rto Rican, etc.)	J-	Black, Whi			
by F	1 □ Never Married 2 □ Married XIXYes 2 □ No □ 942 − If Yes, Give Year or Dates: 1946				1 □ Yes 2 🖾	No Specify:			Specify: w	hite		
었				dent's Usual Oc	cunation		16h	Kind of Business				
Completed	(Specify only highe	nt's Education est grade completed)		(Give	kind of work do DO NOT use re	ne during most of wo	orking		2 20300			
m/	Elementary/Secondary (0-12)	College (1-4or 5+)		Shop M			Pr	inting			
ರ	17. Father's Name (First, Middle.	Last)			2-10p 11		ame (First, Middle					
Be	,	,										
ှ										Zin Code)		
}	June Christopher Garber/Daughter 7379 Swan Point Way, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State											
	1 ☑ Burial 2 ☐ Cremation	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2010 Crownsville, MD										
	21. Signature of Funeral Service	Licensee	M01053			dress of Facility Do				me, P.A.		
	23a. Ratt. Enter the disease, o	r complications that	caused the deati	h. Do not en	ter the mode of	dying, such as cardia	ac or respiratory	arrest,		Approximate Interval Between		
	shock, or heart failure. Lis Immediate Cause (Final				A. 16 A. 1	. 10. 4				Onset and Death		
	disease or condition resulting in death)	a. Duarto	25141	Luonoo ofi:	arai	10/14				Unkno 1/2 yea		
	Immediate Cause (Final disease or condition resulting in death) a. 9astric carcinoma Due to (or as a consequence of): **Pecurvent colon carcinoma* Due to (or as a consequence of): **Pecurvent colon carcinoma*											
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										/		
Ĭ.	Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
Sequentiary list containts, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
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	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of									livon		
Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	death 3	☐Ectopic pregn				23d. Date of delivery Month Day Year			
/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of d nown	eauı 5	Other (specify)						
Ph	Part II. Other significant condit	ione contribution to	heath but not reco	ulting in the	Inderlying cauca	given in Part I	29a Did	tobacc	LISE contribute	to the cause of death?		
þ	¥ .	ons contributing to a	•	· /	inderlying cause	brillati	() _	Yes		Probably 4 □Unkno		
Completed	, ·						24a. Wa		24b. Were a	autopsy findings availa		
mo							per	opsy formed 2	death?			
	25. Was case referred to medic	al				26. Place of De	1 Yes eath (Check only	/	<u>гу</u>	2 = 110		
o Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outnatio	nt 3□ DOA		Home 5□Res		6 DOther (Se	ecify)		
2	27. Manner of Death	28a. Date	e of Injury	28b. Time of	of 28c.	njury at	28d. Describe			ouny)		
ţi	1 Natural 5 ☐ Pendi	ng (Mo	nth, Day Year)	Injury		<i>N</i> ork? 1 ∐ Yes 2 ∐ No						
ica	3 ☐ Suicide 6 ☐ Could	not be 28e Plac	reet, factory, of		28f. Location	(Street	reet and Number or Rural Route Number,					
Certification:	4 ☐ Homicide deteri		ding, etc. (Specif				City or To					
Medical Ce		ing Physician: To the	basis of examina									
led	29b. Signature and title of certifi		nner stated.		29c Lir	ense number		294 [Date signed (Mor	oth Day Year)		
	250. Signature and title of certifi	ne	BZ	re	200. 210	DU140	~	_3U. L	1-10	7011		
~	29b. Signature and title of certifier 29c. License humber D41955 1-19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Obecca Hon MD 6334 Cedav (ave Columbia MD)											
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2	30. Name and address of perso	n who completed cau	use of death (Item	n 23a) (Type	Print)		1.1.0 1	J-	14.0	211/11		
_	Cobella t	on MD	6334	n 23a) (Type	Print)	ane G	lumb	ra	MO	21044		
te	30. Name and address of person 31. Date filed (Month, Day, Year JAN 2	on MD	1221	n 23a) (Type	Print)	ane G	lumb	ra	MO	21044		

11-00306 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Florence Chambers State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day January 11, 2011 Florence Μ. Chambers Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Harbor Hospital If Under 1 Year If Under 24Hrs. **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) 214-96-8314 Director Months Hours Min. 7/7/68 42 1 M 2 X F Usual Residence of Decedent 10a State 10c. City, Town or Location MD Howard Columbia 23a or 28a-f show notified at once. imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10f. Zip Code 10e. Street and Number 7549 Mu Murray Hill Rd, Apt 934 21046 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced Specify ੬ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Waitress 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Benton Chambers Linda æ P 19a. Informant's Name/Relationship (Type, Print) nt of Health and Me it: If item 27 is mu other traumatic e Lindsay N. Pape /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 1/15/11 Donation 5 Other Specify Dod 22 Name and Address of Facility Charles L. S 21.Signature of Funeral Service Licensee Victor Part I. Enter the disease, or complications Physician failure. List only one cause on each line Medical Occlusive Pulmonary Thromboembolism Examiner or condition resulting in death) Due to (or as a consequence of) b. Right Leg Deep Vein Thrombosis Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Overweight, Cardiomegaly Completed 24a. Was an autopsy performed? Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? this No 1 Yes

N/A8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or MD Country) 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Food Service Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21046 7549 Murray Hill Rd, Apt 934, Columbia MD 20c. Location - City or Town, State Hanover MD tevens Funeral Home, Ave, Baltimore MD 2 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Retween Onset and Death Hospital or Attending Physician: The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗸 Yes Other Nursing Home 5 Residence 6 Other 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No c Funeral Director: death. the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 11, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

0226 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17,18,20a-cc22 Per FH C911 1/26/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20T1 Shirley Doane Jänüary 2:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) eb 14, 1973 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Days Hours Min. Director Yrs. Mary land 220**–**86–3482 37 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number ō 1714 Lakeside AVenue 10f. Zip Code 10g. Citizen of What Country? 21218 Funeral items 23a 21222 3033 Ramsey St. USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. black ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: 'natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 721 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 disabled none Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Henry Brown Shirley Ev traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains once. Nathaniel Doane - husband 1714 Lakeside Ave; Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Greenmount Crematory 1/31/2011 BAltimore,MD Signature of uneral Service Inalia 22. Josepholes Russy M 2222 655 W. Baltimore 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list nonditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ξ Pregnant at time of death Month Dav Year ate has been signed by the page 2 should be detached 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2d 9. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? **To the Funeral Director:** After this certificate has I completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Yes 2 No Investigation M 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral C Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death procurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. TECK only one) Signature d title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print or Baltimore, MD 21204 haheen 6701 Charle Year G 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month 2011 :30a 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallstown, 8607 Grayfox Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
04
07 Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 💢 M 2 🗆 F Country) Director 217-40-3793 Usual Residence of Decedent shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Randallstown MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8607 Grayfox Road 21133 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Corp. Steel Worker 10th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ernestine Williams <u>Lewis Durrah</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4406, Pikesville, 23 Clovelly Street, <u>Gwendolyn Durrah-Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) /26/2011 On-Site Baltimore, Md 21. Si nat re of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Av 21215 Baltimore, 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ CON disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** no rear Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 NO Yes Be Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🗹 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home Residence 6 Other (Specify) 27. Manuer of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗆 No Accident 3 Suicide Investigation within 24 hours after deati To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month Day,

(ear)

11-00518 Eric Dorsev, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

En	ic Dorsey, Si	r.	1- For State Registrar	State	e of Marylan		artment o e <i>rtificate o</i>			Mental	Hygiene	Reg. No	20		0 11	552
	Physic		1. Decedent's Nan	ne (First, Middle,La	ast)					•	2. Date of I		Year		3. Time of De	
M	edical Exam	ııner	ELIC	/if not institution o	Euger pive street and numb	ie			sey		Januar	/ 18, 20)11		2243 hr	s
					Medical Center			46. City, Baltir		ocation of De	atn	4	c. County of	Death		
	Funera		5. Social Security I	Number 6.	Sex 7.	Age (In yrs.	last birthday)	If Und	er 1 Year	If Under 24	Hrs. 8. Date of	Birth (MM			place (State	or
	Director		217-66-	4126	X м 2	52	Yrs	Month 5.	s Days	Hours N	^{/in.} 04	24	58	Foreigr Cou		1D
	ķ]	Usual Residence of	of Decedent 10b, County		Ino City	y, Town or Loca									
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0	the M a or 2 tiffed	Dir	5210 Bar	rton Av	Δ.				2120	26			U.S			
0	death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status		12. Was Decede		J.S. 13. Wa	as Decede	nt of Hispa	anic Origin? (Specify Yes or rto Rican, etc.)	No-	14. Race -	Americ	an Indian, Bla	ack,
0	er deat	Fun	1 Never Marri 3 Widowed		1 Yes	2 X No					no Rican, etc.)		White,			
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	5 72 ho sal Ex	Completed	Elementary/Seco		College (1-4 c		during m	ost of wor	king life. D	o NOT use r Cechno	etired)				Comn	a
	15-003 filed within Hygiene. d other that	d HC	12th gra		na		Speci	alis	st				Comp.	Co		
	21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat		17. Father's Name		•				- 1		me (First, Middl		Surname)			
	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "matural", or items 23a or 28a-f sho arise event, the Medical Examiner must be notified at once	5 E	Harry E. 19a. Informant's Na	DOCSE ame/Relationship (Type, Print)		19b. Mailing	Address	(Street a	Madel: Ind Number o	ine Bu or Rural Route N	<u>nn</u> Iumber, C	ity or Town,	State, 2	Zip Code)	_
V.	MD id 2 shoulth and in 27 is aumati	1 1	Eric E.	Dorsey	JrSon		238	Hunt	ers	Run !	Terrac	e, E	Belai	r,	Md 21	.015
V	of Hear triber tr		20a. Method of Dis 1 XBurial 2		Removal from S	20b. State	Place of Dispos crematory or other	ition (Nam	e of ceme	tery,	Date	20c.	Location - C	ity or T	own, State	
A	Baltimore, permit. Pages 1 a Department of He Important: If ite			Other Specify	y:		Meado				29/201	1 E	Elkri	dge	, Md	_
	Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is and injury or other traumatic er		21 Signature of Fu	Ineral Service Lice	d le		Ma	rch	Address of F/H	West						
	Physician		23a. Part I. Enter th	ne disease, or com	plications that cause	ed the death	n. Do not enter ti	ne mode d	f dying, su	ch as cardiad	e Bal or respiratory	C1MC arrest, sho	ock, or heart	Ма	21215 Approximate	Interval
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-			or condition resulting		Due to (or as a con	sequence d	of):									
		miner	Sequentially list con if any, leading to im- cause. Enter Unde	nmediate	Due to (or as a con	sequence o	of):						_			
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	ox 6876 eath certificate attending phy for use as the b		IF FEMALE: 23b. Was decedent past 12 months	pregnant in the	23c. If yes, outco	ome of preg	r	al death	3	Ectopic pregr	nancy	230	d. Date of de Month	livery Day	/ Y	ear
	Box 6876 e death certificat the attending ph ed for use as the	Physician/N	1 Yes 2 N			at time of de	ath =	er (Spec	fy)							-
	D. B. It the de by the ached f		Part II. Other signif		9 Unknown	ith but not re	esulting in the u	nderivina	cause give	n in Part I	23e. Did	tobacco	use contribu	te to the	cause of de	ath2
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	Records, The law require ficate has been si , page 2 should b	Completed									24a. Wa	s an			sy findings a	
	Reco	E									per	formed?	dea		npletion of ca	
	tal Rection: The certificate ector, page	Be	25. Was case referre		In cast of			20		Death (Check						
	Physi Physi er this eral dir	P	1 ✓ Yes 2 27. Manner of Death		lnpati	ient 2	ER/Outpatient 28b. Time of In				ing Home 5		nce 6 (Other:		
	Division of Vital ral or Attending Physician: rs after death. al Director: After this certiled in by the funeral director	Ę	1 X Natural	5 Pending	(Month, Day,	Year)	20b. Time of in	jury Z	3c. Injury a	2 No	28d. Describe	e now inju	ry occurred			
	ViSicon Atta	ifica	2 Accident 3 Suicide	Investigati Could not	28e Place of I	njury - At ho	ome, farm, stree	, factory,	office build	ling, etc.	28f. Location		nd Number o	r Rural	Route Numb	er, City
	Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide	determine							or Town,	State)				
	To the Howithin 24 h To the Fur		29a. Certifier 1 (Check only one)	Certifying Physici Medical Examiner	ian: To the best of n	ny knowledo amination ar	ge, death occurr nd/or investigation	ed at the t	ime, date a	and place, an	d due to the car	use(s) and	d manner as	stated.	auco(c)	
	To the within 2 To the complet	Medical	29b. Signature and t		and manner stated	-	20.941		License nu		uno, dat		ate signed			
X			Co.	al H	LPO 00 a	~	_		O.C.M.E	Ξ.			ıary 19, 2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		-			completed cause of		•									
			Carol Allan, I 31. Date filed (Month		nt Medical Exa	miner 9	900 W. Balti	more S	reet, Ba	altimore, M	1D 21223					
	St Regist			6 2011	Je seura	a a Signatu	parked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

u.o, 2 u		1- For State Registrar	Cert	tificate of Dea		Reg.	No	
Physicia	ın/	Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
ledical Exami	ner		L.		uffie	Month D January 16,		1620 hrs
		4a. Facility Name (if not institution, give st Franklin Square Hospital	reet and number)		, Town, or Location of De edale	eath	4c. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 239-40-3607 Usual Residence of Decedent	7. Age (In yrs. las	st birthday) If Ur Mon Yrs.	nder 1 Year If Under 24 hths Days Hours I	8. Date of Birth (MM/DD/YYYY) 9. Bir Foreig Co	
ku*		10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
th the Maryland 23a or 28a-f show notified at once.	ō	MD NA	1	Baltimor	e			1 Yes 2 No
Maryi rr 28a-	irector	10e. Street and Number		10f. Z	ip Code	10g.	Citizen of What Cour	ntry?
with the	eral D	2829 Lodge Farm	Road 2. Was Decedent Ever in U.S	13 Was Dece	21219 dent of Hispanic Origin?	Specify Vec or No.	U.S.A.	can Indian Black
death w	Funer	1 Never Married 2 Married	Armed Forces?		cify Cuban, Mexican, Pue		White, etc.	can indian, black,
after or	D F	3 X Widowed 4 Divorced If Y	es, Give Year		2 No specify:		, , ,	ack
hours "natu		15. Decedent's Education (Specify only F Elementary/Secondary (0-12)	ighest grade completed) College (1-4 or 5+)		al Occupation (Give kind orking life. DO NOT use		6b. Kind of Business/li	ndustry
036 thin 72 ne. • than	Completed	12th grade	na	Waitr	ess	R	Restauran	t
5-0(iled wi Hygier I other the M		17. Father's Name (First, Middle, Last)	L			me (First, Middle, Mai	den Surname)	
2121 lid be f Mental marke event,	To Be	Raleigh Mason 19a. Informant's Name/Relationship (Type	Print)	19h Mailing Addres	L1ZZ16	Mason	r City or Town State	Zin Cada)
AD 2 2 shou h and h 27 is r		Sandra Cockrell-	,	T.	rlisle Ave			
re, rand i land if item	1	20a. Method of Disposition 1 X Burial 2 Cremation 3	20b. Pl	ace of Disposition (Na ematory or other place	ame of cemetery,		0c. Location - City or	
Pages Pages ment of		4 Donation 5 Other Specify:			al Park 1,	/24/2011	Woodlawn	, Md
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sunstrure of Funeral Service Licensee	Le Re	March	d Address of Facility F/H West Wabash Ave	Baltim	bM each	21215
Physician		23a. Part I. Enter the disease, or complicated failure. List only one cause on each li	ions that caused the death. I	to not enter the mode	of dying such as cardia	or respiratory arrest	shock or heart	Approximate Interval Between Onset and
/Medical Examiner	ı	Immediate Cause (Final disease a. b	H pertensive	Atherosc1	lerotic Card	iovascular	Disease	Death
		h	to (or as a consequence of):	and Diabe	etes Mellitu	S		
	힐	Sequentially list conditions, if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of):					
-	Examiner	(Disease or injury that initiated C	to (or as a consequence of):					
		d. X UNPENDED A	MENDED 23a,27 p	er me ogl	3 3_28_11 11	F		
60, ate be er hysiciar e burial	Medical		3c. If yes, outcome of pregna		3 3-28-11 V		23d. Date of delivery	
6876 ertifica ding ph		23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal death	3 Ectopic preg		Month Date of delivery	ay Year
ords, P.O. Box 687 w requires that the death certificate is green signed by the attending particular because as the strength of the strength	Physician/	1 Yes 2 No 9 Unknown	Pregnant at time of deat	h 5 Other (Spe	ecify)			
P.O. Es that the canada by the detached		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
S, D uires th	ed by					1 Yes 2		ibly 4 🗸 Unknown
aw req	Completed					24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
Rec The 1 ficate b	5					performed 1 Yes 2	d? death? No 1 ✓ Yes	2 No
rital sician:	ďΙ	25. Was case referred to medical examiner?	tal: 1 ✓ Inpatient 2 E	R/Outpatient 3 I	26.Place of Death (Chec	k only one) sing Home 5 Res	idence 6 Other:	
of V ig Phy free th neral d	٩	27. Manner of Death		8b. Time of Injury	28c. Injury at Work?	28d. Describe how		
ion itendir leath. for: A	텵	1 X Natural 5 Pending 2 Accident Investigation	(WORTH, Day, rear)		1 Yes 2 No			
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom (Specify)	ne, farm, street, factor	y, office building, etc.	28f Location (Street or Town, State	et and Number or Rura)	l Route Number, City
o the Hos	ल	one) 2 Medicai Examiner:On	To the best of my knowledge, the basis of examination and manner stated.					
F S F S	ž	29b. Signature and title of certifier	1/70	29	c. License number		d. Date signed (Mont	h, Day, Year)
		/ flen Bras	elful		O.C.M.E.	Ja	anuary 17, 2011 	
		 Name and address of person who comp Melissa Brassell, MD Assis 	leted cause of death (Item 23 tant Medical Examine		more Street, Baltim	ore, MD 21223		
Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	barkel				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0430M DONATI ELIZABETH T-2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Mangland Medical Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Hours 78 0473071932 Maryland 213 28 8722 Yrs Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 141 W. Meadow Road 21225 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob E. Lulay Ethna P. O'Burn permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 Ellen Endres / Daughter 17 Proctor Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Glen Haven Mem. Park: 01/27/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Our 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Demente Severe disease or condition leavs Medical resulting in death) Examiner 1 monte Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) be detached the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe After this certificate 1 Yes 2 No Yes 2 **X** No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Kinpatient 2 🗆 ER/Outpatient 3 🗆 DOA the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director:. Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) P2305 ESIDENT address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BENADETTE

MAKORI-NELSON

32. Registrar's Signature

SOUTH GREENE ST.

DALFONZO 的を付める Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Pri						_	•	ble.	
		for State	State of Ma	arylan		partment of I		ind Menta	al Hygie	ne	Ber 107	01005
		Registrar 1. Decedent's Name (First, Middle, La	st)			ertificate of l	Jeain	2. Dat	Reg. e of Death	No.4 U	1 1	3. Time of Death
Physicia Medic			Betty Jea	an Da	1fon	Z0		JAN	nth DUALS	Day 2	Year	5:40 PM
Examin	er	4a. Facility Name (If not institution, give BAITIMBRE WASH)	street and number)	. 10	. 170	4b. City, Town, o		Death		4c. County o		, ,
Funeral		5. Social Security Number 6. S	ex 7. Age		st birthda	y) If Under 1 Year	If Under 2	4 Hrs. 8 Dat	e of Birth	Anne		place (State or Foreign
Director		215 28 4930 1 Usual Residence of Decedent	□ M 2 🔀 F	77	Yrs	. Months Days	Hours	Min. (Mc	nth, Day, Yes 5/14/1	933	Mar	yland
land show dat	tor	10a. State 10b. County		10c. City	, Town or	Location					10	Od. Inside City Limits
e Mary - 28a-f notifie	Funeral Director	, , , , , , , , , , , , , , , , , , , ,	Arunde1		G1en	Burnie						1 🗌 Yes 2 🕱 No
vith the 23a or st be	aral [10e. Street and Number 1039 Dumbarton	Road			10f. Zip Code	21060		10g.	. Citizen of Wh		try?
death vitems	Fune	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	i. 1	3. Was Decedent of H If Yes, specify Cuba		n? (Specify Yes	or No-	U.S.		an Indian,
after or all, or xamir	d by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 i If Yes, Give	No		1 ☐ Yes 2 ♣ No		Puerto nican, e	ic.)	Black, Specify:	White, e	ite
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thin 72 ene. than ' he Me	Completed	Elementary/Seconday (0-12) 8th	College (1-4 or 5	+)	life	ve kind of work done of DO NOT use retired)	during most o	of working		0	7.7	,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)			п	omemaker	18. Mother	's Name (First, i	Middle, Maid		1 Ноп	ne
	욘	Marvin Scott Annie Pearl Finch									1	
2 shouth and the and the strain t	1	19a. Informant's Name/Relationship (7) Mary Saunders /				ailing Address (Street a						
1 and of Heal item?		20a. Method of Disposition			ace of Dis	position (Name of		Date		Location - C		1and 21060 wn, State
Page ment tant: If lury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y)	Bay	view	rematory or other place Crematory		1/25/20	11 Ba	altimor	e, N	Maryland
permit Depart Impor any in once.		21. Signature of Fulleral Service Licens	alin al	2		22. Name and Addres	s of Facility	Gonce	Funera	al Sery	/ice	P.A.
		23a. Part 1. Enter the disease, or com	olications that caused	the death	. Do not e					nore, N		Land 21225 Approximate
Physician.	ë Ar	shock, or heart failure. List only o Immediate Cause (Final disease or condition			-al	Infrance	TION					Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):	110						
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eath certificate be attending physici i for use as the bu	Medi	IF FEMALE:	d									
ath cer attendii for use	cian/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at	Petal	death 3	Ectopic pregnanc	y			23d. Date		y Day Y ear
the de	hysi	1 ☐ Yes 2 ☐No 9 ☐ Unknown	g Unknown	unie or de	satii c	Other (specify)				IVIOITI		ay rear
requires that the de been signed by the should be detached	Completed by Physician/Medical	Part II. Other significant conditions of	ntributing to death bu	t not resu	Iting in the	e underlying cause giv	en in Part I.	236				cause of death?
requir been s should	leted											ably 4 Unknown
he law te has age 2	g l								. Was an autopsy performed: Yes 2	pric	or to com th?	sy findings available upletion of cause of
sician: The law r s certificate has b lirector, page 2 s		25. Was case referred to medical examiner?	In a state					(Check only one		No. 1L	Yes 2	: LI No
Physi r this o eral din	<u>၉</u>	1 ☐ Yes 2 ☑No 27. Manner of Death	Hospital: Inpatier 28a. Date of injury	nt 2 🗆 E	R/Outpat 28b. Time	ient 3 DOA Othe of 28c. Injury	4 ☐ Nurs	ing Home 5		6 Other (Specify)	
ending eath. or: Afte he fune	licat L	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	work?			onde now in	ury occurred		
or Att after d Direct in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At hom (Spec <i>ify)</i>	ne, farm, s	street, factory, office			ition (Street a or Town, Sta	and Number o	r Rurai R	loute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicist completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowle	dge, deat	n occured at the time,	date and pla	ice, and due to	the cause(s)	and manner a	s stated.	
the He thin 24 the Tue The Tue The Fu		only one) 3 \square Certifying Nurs	ner: On the basis of exa e Practioner: To the b	est of my l	and/or inve knowledge	, death occurred at the	time, date ar	rred at the time, nd place, and du	date and pla e to the caus	ce, and due to e(s) and mann	the causer as state	e(s) and manner stated. ed.
5 8 8 8 9 9 9		29b. Signature and title of certifier	soin M	2		29c. License	T41	5	29d. [Date signed (N	lonth, Da	iy, Year)
	-	30. Name and address of person who c	47	ath (Item 2	23a) (Type	Print) More WA	1		J 7 1	TOU MY	· / L	-6, 2011
Ctot		Identy FRANC 31. Date filed (Month, Day, Year)	32. Registra	Bi	カナ	more WA	shing	gton /	Madica	1 (e	rtel	
State Registra			2011 ▶ 1	Jean J	A	hard						

DHMH 17 Rev 7/2009

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 213 AM anucuru 2 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA John Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Firth (Month) Day, Year) **Funeral** Days Months Min. 1**X** M 2□ F 69 Yrs. 2**17-**38-8523 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 2117 Christian Street by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African filed within 72 hours after 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Roofer Roofing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If Item 27 Is marked oth any injury or other traumatic event ONG. Be Alice Downs John William **Epps** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Christian Street Baltimore, MD 21223 Nannie M. Epps-Fiance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01-26-11 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral 89 vice License 638 N. Gilmor Street Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bowel obstruction abdominal compartment Syndrome /Medical Due to (or as a consequence of): Examiner SEPSIS Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Examin and burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. as been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has page 2 s autopsy prior to completion performed death? 1 ☐Yes 2 No 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Unpatient 2 ER/Outpatient 3 DDA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 22, 20**1**1 Baltimore, MD 21287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 600 N. Wolfe Street CH RISSIW (M) JONATAMO (32. Registrar's Signatur 31. Date filed (Month, Day, Year) State JAN 26 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 01 2011 6:55a.M Eppes Medical Joan 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min (Month, Day, Year) Country) 59 Director MD 14-56-6061 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director MD Baltimore Cockeysville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a any injury or other traumatic event, the Medical Examiner must be a once. Funeral 21030 Place Apt U.S.A. Vallev Lake and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty 12th grade 3yrs+ Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Burke James Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valley Lake Place, Cockeysville, Md 21030 Janelle Eppes-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 1/28/2011 Woodlawn, Md King Memorial 21. Si mature of Funeral Service Licens March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) signed by the a Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Hospital or Attending Physician; The law 1 24 hours after death. Funeral Director: After this certificate has b autopsy performed Yes 2 page 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 🗌 Yes ျှ 4 Nursing Home 5 Residence 6 Other (Specify) No Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 29a. Certifier 1/E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check

To the Hospital or Atter within 24 hours after de: To the Funeral Director completed filled in by th Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 L 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMON MANNES 6701 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

2011

2

No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Certificate of Death	01668
	Physic //Medi		1. Decedent's Name (First, Middle, Last) ROSCOE E. Ervine 2. Date of Death Month Day Year ANUGOU 9 2011	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) Senessis Caton Manor Baltimore 4b. City, Town, or Location of Death Baltimore N/A	1
	Funeral Director		5. Social Security Number 225-16-2814 6. Sex 132M 2 F 92 Yrs. Social Security Number 1 Security Number 225-16-2814 92 Yrs. Social Security Number 24 Hrs. Social Security Number 25 Social Security Number 26. Sex 15 Security Number 27 Security Number 27 Security Number 28 Security Number 28 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 20 Security Number 20 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 29 Security Number 20 Security	ace (State or Foreign try) VA
	Maryland f show ied at	tor	10a. State 10b. County N/A 10c. City, Town or Location	0d. Inside City Limits 1XX es 2 □ No
	with the 3a or 28a- t be notif	Funeral Director	10e. Street and Number 2130 Whistler Avenue 10f. Zip Code 21230 USA	
9	BAITIMOYE, IMARYIANG 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Specify: Wildowed 4 □ Divorced If Yes, Give	
ı	Saltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. mportant: if item 27 is marked other than "natural", or my hiury or other traumatic event, the Medical Exami noce.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker Manufactu	·
-	land 2.	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	ring
	Mary and 2 shou alth and M 27 Is mar	-	19a. Informant's Name/Relationship (Type. Print) Margaret J. Semone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 2130 Whistler Avenue, Baltimore MD	^{Code)} 21230
	Pages 1 gment of He ant: If item ury or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Tow 20c. Location - City o	MD
	Depart Depart Import any Inj		21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore	Inc. MD 21230
	Physician / Medical Examiner physician and the pnual-transit the pnual-transit the pnual-transit the pnual-transit that the pnual-transit	dical Examiner	shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
3	DOX of auth certification of for use as	Physician/Medic	9 Unknown 9 Unknown	y Day Year
3	w requires that the deben signed by the should be detached	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
- C	VICAL DECC	Completed by	autopsy prior to compleath? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2	sy findings available opletion of cause of
15	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify))
Scor Ervine	To the Hospital or Attending Physicial Authors after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	27. Manner of Death 1	Route Number,
S	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	dical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause (s) and manner as stated and place, and due to to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to to the cause (s) and manner stated.	ited. the cause(s)
4	To the within To the comp	Me	29b. Signature and title of cartified MD 29c. License number 29d. Date signed (Month, Date of 2634) TAN 20, 201	
	HA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATISEN AWAN 1°796 HICKERY RIDGE RD COLVMB 1A MD 21044 31. Date filed (Month, Day, Year)	
h	Sta Registr		31. Date filed (Month, Day, Year) 32. January 32. January 32. January 32. January 32. January 33. January 34. Jan	

11-00584 .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph Anton F	enc	1- For State Registrar	ate of Marylar		artment of <i>rtificate of</i>		nd Ment	al Hy		g. No.	4 U I	1 01563
Physici Medical Exam		Decedent's Name (First, Midd	le,Last) ANTON	FENCL					2. Date of Deat Month January 2	h	Year	3. Time of Death 0930 hrs
		4a. Facility Name (if not institution 7116 Ducketts Lane #	n, give street and numb	per)		4b. City, Town, o	or Location of			4c. C	County of De	eath
Funeral Director		5. Social Security Number 171–44–0605	6. Sex 7.	Age (In yrs.	last birthday) 59 Yrs	If Under 1 Ye		24Hrs. Min.	8. Date of Birt	h(MM/DD	D/YYYY) 9.	Birthplace (State or reignPENNSYLVAN1
w any		Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Locat	on						10d. Inside City Limits
Maryland 28a-f show any 1 at once,	Director	MARYLAND HO 10e. Street and Number	OWARD CO			ELKR 10f. Zip Code	IDGE		10	g. Citizer	n of What C	1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once,		7116 DUCKETT:	5 LANE #302		.S. 13, Wa	2107 s Decedent of H		n? (Spe	cify Yes or No-		S.A.	nerican Indian, Black,
r death or iter	by Funeral	3 Widowed 4 Div	arried Armed Forc 1 Yes orced If Yes, Give Year or Dates:	2XX No	1	es, specify Cuba	n, Mexican, I specify:	Puerto R	ican, etc.)	Sp	White, etc	i. ITE
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	eted	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4		during mo	's Usual Occupa					d of Busines	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	e Comple	12yrs 17. Father's Name (First, Middle,	,		СНЕМІ	ST			First, Middle, M			ERNMENT
D 2121 should be fil and Mental H is marked	JAMES R. FENCL JOAN T. CARTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or									or Town, Sta	ate, Zip Code)	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		Joan Fenc1/Mot1 20a. Method of Disposition 1 XXBurial 2 Cremation			32 We Place of Disposi crematory or oth	st Ave. tion (Name of ce er place)	, Ocea	in Ci	Date NJ			or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Sp 21. Signature of Fuperal Service	ecify:	Olule	EASIDE C	EMETERY					-	NEW JERSEY
ம் கூறி நிர் Physician		25a. Part I. Enter the disease, or	complications that caus	ed the death.	1 12	.06 W NO	RTH AV	ENUF	E. BALT	TMOR:	E. MD	HOME P.A. 21217
/Medical	,, °	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Atheros	clerot	ic Card					or, snock,	orneart	Between Onset and Death
	7.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co									
	Examiner	cauce. Enter Underlying Cauce (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co							_	_	-
O, the executed sician and purial - transit	edical E	X UNPENDED	d AMENDED	23a,27	per me	g913 3-	-10-11	vt			-	
Box 68760, c death certificate be en the attending physician of for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregr	nancy 2 Feta	al death 3	Ectopic p		у	23d. Da	ate of delive	ery Day Year
4 4 4	Physician/M	1 Yes 2 No 9 Unk	9 Unknown		□ Oth	er (Specify)	river is Dest		Logo Did tob			to the cause of death?
s, P.O. uires that the n signed by Id be detached	<u>a</u>		contributing to de			derlying cause (jiven in Part			_		obably 4 Unknown
Division of Vital Records, ral or Attending Physician: The law requints after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed								24a. Was ar autopsy perform	red?		
Vital Rec hysician: The I this certificate I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatient		of Death (CI		yone) Iome 5 R	esidence	6 🗸 Oth	er: Scene
on of canding Phast. or: After the funeral		27. Manner of Death 1 X Natural 5 Pendi		njury v,Year)	28b. Time of Inj		ry at Work? ∕es 2 N	- 1	d. Describe ho	w injury o	occurred	
Division pital or Attencours after death	Certification:	- [not be	Injury - At ho	me, farm, street	, factory, office b	ouilding, etc.	28	f. Location (Str or Town, Sta		Number or F	Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 CertifyIng Phyone) 2 Medical Exam	ysician: To the best of niner: On the basis of ex and manner state	amination ar	e, death occurre	ed at the time, da	ate and place , death occur	, and du	e to the cause(e time, date ar	s) and ma	anner as sta and due to	ated. the cause(s)
	ž	29b. Signature and title of certifier	Shell			29c. Licens O.C.I					signed (M y 22, 201	lonth, Day, Year)
Read		30. Name and address of person v Margarita Korell MD.	Assistant Medica	l Examine	er 900 W.	Baltimore St	reet, Balti	more,	MD 21223			
Sta	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatur	-							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 300 PM Medical Z 01 CAVI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death sture timo 8. Date of Birth (Month, Day, if Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑M 2 ☐ F Days Months Hours Min. Country) Director 3-38-180 Yrs Usual Residence of Decedent and Mental Hygiene.

i sand Mental Hygiene.

i is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral \mathbf{a} a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: If Yes, Give Specify: 3 Divorced Year or Dates permit. Page 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suri ည lam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32779 Nanc 200 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date UNK ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Allentown 21. Signature of Funeral Service Lice 22. Name and Address of Pacility PA 18434 dvalley 193 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as contents, or heart failure. List only one cause on each ling. 23a, Part 1 Approximate Interval Between Immediate Cause (Final t and Death ATMIOSCLEWARC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and -trans Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Yes 2 □ No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 2 N Division of Vital Be Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital 2 W No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29c. License number 000 43375 29d. Date signed (Month Day, Year) 2010 ss of per completed cause of death (Item 23a) (Type Print) SUITE 203 PARTUNDE, MI) WELROTT 31. Date filed (Month, Registrar's Signature State Registrar

11-00545 Mark Falkenhan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

fark Falkenhan		State of Maryland / Department 1- For State Certificate Registrar		011 0167
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Middle,Last) Mark G. Falkenhan	2. Date of Death	3. Time of Death 2016 hrs
		Facility Name (if not institution, give street and number) St Joseph's Hospital	4b. City, Town, or Location of Death 4c. Coun	nty of Death
Funeral Director		5. Social Security Number 212-06-9016	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YY Months Days Hours Min. 12/26/67	9. Birthplace (State or Foreign Country) MD
ow any		Usual Residence of Decedent 10a. State	ation Essex	10d. Inside City Limits 1 Yes 2 XNo
e Maryland or 28a-f show any	Director	10e. Street and Number 406 Theresa Avenue		What Country?
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28s-f sho numatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes, specify Cuban, Mexican, Puerto Rican, etc.) We 2 X No specify: Specify:	D. sissa alle di sate i
21215-0036 Id be filed within 72 hours after formal Hygiene. narked other than "natural", event, the Medical Examiner.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Emer	most of working life. DO NOT use retired) gency Services Specialist	ecret Service
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Bec	17. Father's Name (First, Middle, Last) Casper J. Falkenhan	18.Mother's Name (First, Middle, Maiden Surnar Gloria Mae Gra	ay
MD 2 nd 2 should alth and M m 27 is m aumatic c	٩	Gladys Falkenhan / Wife 406	ng Address (Street and Number or Rural Route Number, City or To Theresa Avenue, Essex MD	21221
Baltimore, MD 21 pemit. Pages I and 2 should Department of Health and Me Important: If item 27 is me injury or other traumatite		1 XXBurial 2 Cremation 3 Removal from State Dulaney	wherplace) Valley Mem. Gardens Ba	on-City or Town, State
		21. Signature of Funeral Service Licensee Victor P. Doda 22.	Name and Address of Facility Charles L. Stevens Funera 501 E. Fort Ave, Baltimore	l Home, Inc. e MD 21230
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Thermal Injuries	the mode of dying, such as cardiac or respiratory arrest, shock, or l	heart Approximate Interval Between Onset and Death
- J		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
executed an and al - transit	edical Ex	d	per me g912 2-4-11 vt	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial – transi	2	1 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregnancy 23d. Date Month	
res that the c signed by the	P P	Part II. Other significant conditions contributing to death but not resulting in the		ntribute to the cause of death? 3 Probably 4 Unknown
Records The law requi	Completed		24a. Was an autopsy performed? 1 ✓ Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 ves 2 No
Vital Recysician: The his certificate director, page	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien	26. Place of Death (Check only one) t 3 DOA Other Nursing Home 5 Residence 6	6 Other:
on of tending Pheath. or: After the funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time or (Month, Day, Year)	1 Yes 2 No	
Divisi pital or Att ours after de ieral Direct	Certification	2 X Accident Investigation 3 Suicide 6 Could not be determined Homicide 1 Could not be determined (Specify) Multi-family	eet, factory, office building, etc. 28f. Location (Street and Num	nber or Rural Route Number, City Dowling Circle Md.
p i i i	edical C	(one only	arred at the time, date and place, and due to the cause(s) and mann ation, in my opinion, death occurred at the time, date and place, and	
To so and a so a so a so a so a so a so a so a s	₩.	29b. Signature and title of certifier	29c. License number 29d. Date sig O.C.M.E. January 2	gned (Month, Day, Year) 20, 2011
N.	ŀ	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 90	W. Baltimore Street, Baltimore, MD 21223	
Sta Regist		31. Date filed (Month, Day, Year) 32. Redistrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	_ State	ate of Mar	-	•	ment of H icate of D		Mental Hy	GIENE Reg. N	0011	01672	
			1. Decedent's Name (First, Middle, Last)				roato or E	- Catir	2. Date of De	ath	Emm U 1 1	3. Time of Death	
	Physicia Medic		JOHN W. GREENBECK						JÄNÜAR	Y 2	2, 2011	8:10 A.M	
ph in	Examin		4a. Facility Name (if not institution, give street a			4k		Location of Dea	th	4c. County of Death			
-4-	<i>F</i>		3333 WOODSIDE AVENUE 5. Social Security Number 6. Sex		n yrs. last birtho	day) If	PARKV Under 1 Year	If Under 24 Hr		irth BALTIMORE 9. Birthplace (State or Foreign			
	Funeral Director		216-03-5459 1X M 2	□ F		rs. M	onths Days	Hours Min	. (Month, Da 11/24/	ıy, Year) 191 (yrt,AND		
	od at	l. I	Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town	or Location	on					10d. Inside City Limits	
	72 hours after death with the Manyland "natural", or items 23a or 28a-f sho hedical Examiner must be notified at	Director	MD BALTIMORE		PA	ARKVI	LLE					1 ☐ Yes 2 X No	
	the M		10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?	
	s 23a	Funeral	3333 WOODSIDE AVENUE				21234			USA			
	death r item ner n		Ari	as Decedent Eve med Forces?		13. Was If Ye	Decedent of His s, specify Cubar	spanic Origin? (\$ n, Mexican, Pue	Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, White		
36	after al", or Exami	d by	1 Never Married 2 Married 17 3 X Widowed 4 Divorced Ye	☐ Yes 2 ☐ No Yes, Give par or Dates. W	WII	1 🗆	Yes 2 XNo	Specify:			Specify: WHITE		
9-0	hours natur dical	olete	15. Decedent's Education (Specify only highest grade com	n	16a. Decedent's Usual Occupation 16b. Kind of						Kind of Business		
21215-0036		Completed		ollege (1-4 or 5+)	, h	ife. DO N	OT use retired)	aring moot or m	g	G		T PRINTING	
2	ed within Hygiene. other than ent, the N	اما	12TH GRADE 17. Father's Name (First, Middle, Last)		PF	RINTE	LR. E	18. Mother's Na	ame (First, Middle,	Maider	OFFICE Surname)		
lan	ould be filed nd Mental Hy marked oth maric event	힏	JOHN E. GREENBECK						BLOOM				
Maryland	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Pri	nt)	19b.	Mailing A	ddress (Street a				or Town, State, Zip	Code)	
	1 and 2 should be f Health and Men item 27 is marke other traumatic		JOHN E. GREENBECK/SC				EYS COU	RT NOT	TINGHAM,		21236 Location - City or	Town State	
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remove		20b. Place of I	Disposition of Company (No. 1975)	on (Name of ory or other plac FAITH	e)	Date				
Itin	- P + -		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MC	M212-		CEME	YFRY	: 1/			RKVILLE.	OME, P.A.	
Ba	permit Depar Impor any in		12	Oh:				RAVEN B				1286	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.										Approximate Interval Between	
~	Physician/		Immediate Cause (Final disease or condition	DeG	ility							Onset and Death	
-	Medical taminer		resulting in death)	Due to (or as a c	onsequence of	f):						•	
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	ate be executed physician and the burlal-transit	a E	resulting in death) Last	Due to (or as a c	onsequence of	f):							
09	ate be chysic the bu	edical	d										
687	certific ding partitions partitions	M/u	IF FEMALE: 23c. If	yes, outcome of	pregnancy						23d. Date of de	livery	
Box 68760	Attending Physician: The law requires that the death certific ardeath. eard cash. eard After this certificate has been signed by the attending is other funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	Live Birth 2 Pregnant at til Unknown			ctopic pregnand ther (specify)	У			Month	Day Year	
0. E	f the c by th	Phy	9 Unknown Part II. Other significant conditions contribut		not resulting in	the unde	erlying cause giv	en in Part I.	23e Did t	hobacco	use contribute to	the cause of death?	
, P.O.	es tha signed I be de	d by	pulmmaryhyper						1			robably 4 🗆 Unknown	
ords	v requires been sig should b	lete	044 0/2 1 2/25(1)	lan à	1.1-1	•			24a. Was		24b. Were au	topsy findings available	
of Vital Records,	The law ate has page 2:	Completed by	perpara visco	TIME C					auto perfe	ormed?		completion of cause of	
alF	ician: The law certificate has rector, page 2	Be C	25. Was case referred to medical examiner?					ace of Death (Ch		- /			
. Vit	Physician: this certific al director,	မ	1 ☐ Yes 2 🕅 No	1 Inpatient	2 ER/Out			4 L Nursing			6 Other (Spec	ify)	
n of	ding Phy h. After thi funeral	ate	1. Natural 5 Pending	Ba. Date of injury (Month, Day, Y		jury	28c. Injury work M 1		28d. Describe	now inju	ary occurred		
Division	Attending the death.	Certificate:	o Douteide C Doute not be	e. Place of Injury	- At home, farr	m, street,	factory, office		28f. Location (ation (Street and Number or Rural Route Number,			
Divi	tal or rs afte al Dire			building, etc. (
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu	Medical	29a. Certifier (Check 2 Medical Examiner: Or	the basis of exar	mination and/or	investiga	tion, in my opinio	n. death occurre	d at the time, date	and place	e, and due to the	cause(s) and manner stated.	
	o the //thin 2 the omple	ž	only one) 2 Certifying Nurse Prace 29b. Signature and title of certifier	ctioner: To the be	st of my knowle	edge, dea	29c. License			204 D	ate signed (Mont)	Day Year)	
	->-0		> Gerouli	0			105	830	3	19	nuar	124 2011	
I			30. Name and address of person who complete	ted cause of deat	th (Item 23a) (T			10	20100	Ca	- フシレン	124 2011 00 MD	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	<u>(=</u>	701	, , ,	SEICE	. 34	, 00		
	Registr		JAN 2.6 2011 /2	Lesche .	A. DO	wee	7						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DARNICE RENITA **GETHERS** Medical JAN 2011 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges #202 Hyattsville 5725 Cypress Creek Dr. If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) DC 1 🗆 M 2 🖾 F Months Days Hours Min. Jan 23, Year 974 Director Yrs 577-96-0169 36 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Prince Georges Hyattsville 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 5725 Cypress Creek Dr. #202 USA 20782 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 ☐ Married ð Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Black injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Williams Meter Service Scheduler yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Joseph Francis Gethers Clovia Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau Veronica Kelly - Sister 2910 Troy P1 District Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1-17-2011 Alexandria, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland clarine 4308 Suitland Rd. Suitland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breast Cancer disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or ii that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the be detached ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate ☐ Yes 2 🛮 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: ြုင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 24 hours after death Funeral Director. 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the F only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 1/14/2011 D0059061

DHMH 17 Rev 7/2009

State Registrar Hospital Rd.

32. Registra's Signa

Suite 212

20678

Prince Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110

Arati Patel,

31. Date filed (Month, Day, Year)
JAN 26 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene') 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAN . 24 Pay THOMAS GIBSON, JR. 20 TT 1:30 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2366 NORTHCLIFF DR. HARFORD **JARRETTSVILLE** 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) CT. 5. 1939 Country) **Director** 214-38-8087 71 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD HARFORD JARRETTSVILLE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2366 NORTHCLIFF DR. 21084 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. WHITE 72 hours after ģ 1 Never Married 2 Married Maryland 21215-0036 2 🔀 No ☐ Yes 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced If Yes, Give Year or Dates Specify: "natural", Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) ELECTRICAL ENGINEER WESTERN ELECTRIC and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ THOMAS L. GIBSON, SR. EMILY HELEN STERNAT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbe 2 RUNWAY CT MID Number or Rural Route Number, City or Town, State, Zip Code) ${
m MIDDLE}\ {
m RIVER}$, ${
m MD}\ 21220$ permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra THOMAS GIBSON, III-SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or 1/29/11 PARKWOOD CEMETERY BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a Part 1 Enter the displaye, or complications that caused shock, or heart failure List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NON disease or condition Month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine sequentially list containers, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital nours after death.

neral Director: After this or
filled in by the funeral dire 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 20a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OOPER 714 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1,4a per doc, 10e, 19b per fh g911 1-26-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Harvey Lee Gordon 2. Date of Death 3. Time of Death Physician/ Month 2/Day 125 PM 2011 Medical 4a. Facility Name (if not institution give 4b. City, Town, or Location of Death Examiner DRIVE 4c. County of Death 3000 STONE CLIFF #102 BALTIMORE ROAD, BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🕅 M 2 🗆 F Months Hours Min Director 84 Yrs. 1070471926 218-18-4391 Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD BALTIMORE BALTIMORE 10e. Street and Number DRIVE 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 STONE CLIFF ROAD, #102 21209 12. Was Decedent Ever in U.S.
Argued Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ SALES MENS CLOTHES Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev LOUIS GORDON FANNIE PRISMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3000 STONE CLIFF ROAD, BALTIMORE, MD 2120 ARLENE GORDON / WIFE BALTIMORE, MD 21209 #102 20a. Method of Disposition 20c. Location - City or Town, State Riace of Disposition (Name of Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) BETH ISRAEL 01/24/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Signature of Funeral Service Licenses INC. MD 21208 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death ed by the a 1 Yes 2 L 9 Unknown 2 No 9 Unknown P.O. signed by i Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page performed? Yes 2 No 2 🗌 No 1 Yes **Division of Vital** s after death.

Director: After this certificd in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотрыете To the within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6938 Aviation 31. Date filed (Month, Day, Year)

JAN 26 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2011 Ann Reichenbach Hall 11:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Silver Spring Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Oct. 14, 1 □ M 2XXF Year) 1936 Pennsylvania Months Days Hours Min. 294-32-5531 74 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo MD Prince George's Silver Spring 10e Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 3160 Gracefield Road, #3138 20904 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married ģ 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland College (1-4 or 5+) 5 + Elementary/Seconday (0-12) State Government Mental Health Counselor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Hugo Oscar Reichenbach III Madeline Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 Leta Hall / daughter 8600 16th St #811, Silver Spring, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) West Arundel Crem. 1/25/2011 Odenton, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Unknown Multiple sclerosis - advanced disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 Yes 2XXNo Month Year 5 Other (specify) Pregnant at time of death 9 Unknown the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dysphagia 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law After this certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural work? within 24 hours after death. To the Funeral Director: Af completed filled in by the fu death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

10V

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

Eileen Gemmell 3160 Gracefield Road, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver Spring, MD 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

20904

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Dec: Eula Mae Harri

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HARRIS Physician/ Jan. 2011 16:50 R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** East Preston Street Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral Country) SC 1 □ M 2🏝 F Months Hours Min. 04-13-26 214-20-4977 84 Director Usual Residence of Decedent show at 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director r 28a-f sh notified a MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be a Funeral with 1 USA 21203 Preston Street Apt Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African Armed Forces' þ 1 Never Married 2 Married ☐ Yes 2 X No 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify:American Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home maker 9th Grade aborer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Archer Bi11 Douglas 19a. Informant's Name/Relationship (Type, Print) Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Charlene Walker Clifton Byberry Road Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or of 1 Donation 5 ☐ Other (Specify) 02-02-11 | Owing Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Street 638 Ν. Gilmor Baltimore, MD 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ IFBILLIT Medical Due to (or as a consequence of): Examiner TROIAC ARRYTHM(A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit Exam CHEMIC Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) -burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death pec the a Unknown s been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 W No After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1
Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 🗆 No 24 hours after death. Funeral Director: A within 24 hours after death

To the Funeral Director: /
completed filled in by the Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VL 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 26 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 4:20 PM ANJAR Harley Jr. Oscar 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0/= SINAL HOSPITAL BALTIMORE BALTIMORE Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 08 23 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Months Country) Director 215-12-4982 86 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21207 U.S.A. 3014 Ferndale Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 21215-0036 Completed by 1 Never Married 2 X Married 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4 or 5+) 5yrs Coppen State Colleg¢ Chief Police Officer Be Maryland 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Essie Harley Oscar S. Harlev Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Harley-Wife
20a. Method of Disposition Ferndale Ave, Baltimore, Md 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 2/1/2011 Owings Mills, Md 21. Signeture of Funeral Service Licensee 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, INSULIN DEPENDENT DIABETES 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital 1 Yes 2 No Other: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number mo RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TURK BALTIMORE SINAL HOSPITAL OF 31. Date filed (Month State 6

DHMH 17 Rev 7/2009

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1²3^y JAN. 2°0°11 4:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SANCTUARY AT HOLY CROSS BURTONSVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕮 Days Hours 10/26/ 243 - 26 - 2663 NORTH CAROLINA 8 7 Yrs 1923 **Director** Usual Residence of Decedent ı "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3116 N ST., NE 20019 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: BLACK 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **EDUCATION** SCHOOL TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NELSON B. DUNHAM LOUISE ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WREN LANE LANHAM MARCIA HARRIS/DAUGHTER 7017 MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEM. 1/29/11 BRENTWOOD, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 20002 1425 MARYLAND AVE., NE WASHINGTON, DC 23a. Part 1. Enter the disease, shock, or heart failure. Lis r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. adv auco Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Dunity (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ≥ □ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 performed 1 ☐ Yes 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00069829 completed cause of death (Item 23a) (Type, Print) Smith Ave, suite 203, Baltimore MD NAQVI , 2835 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 7:25 AM CLA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hos arbor rital ltimore N/A a 6. Sex If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Davs Hours Min (Month, Day, Country) Mar v 1 and Director 220 24 2974 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 21225 5339 Wasena Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🛣 No ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White "natural", 3 x Widowed 4 ☐ Divorced Completed er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker 8th 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Lucas Anna Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 8 195 Hickory Point Road Pasadena, Maryland 21122 Ruth Congleton / Daughter Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01/26/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 21. Signalure of uneral Service Do 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ eumonia disease or condition resulting in death) in Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Sle attending physician and for use as the burial-transit myo colody Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No 4 Pregnant a Pregnant at time of death 5 Other (specify) signed by the af d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a. Was an page 2 autopsy certificate has performed funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ည 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title License numbe Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hanover St., Baltimore Raines Harbor 31. Date filed (Month, Day, Year) 32. Register State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/20/201 Thomas A. Hren Physician/ 22:43 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Health System Chestertown, Kent MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral X**XM 2 □ F Hours (Month, Day, 8 / 2 0 / 74 **Director** MD Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10d, Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Kent Chestertown 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27370 Morgnec Road 21620 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14⊒4'es 2 □ No Na If Yes, Give Gu 11. Marital Status 14. Race - American Indian Nati Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White Yes 2 X No 59-62 Specify. 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Thomas John Hren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 27370 Morgnec Rd, Chestertown MD 21620 19a. Informant's Name/Relationship (Type, Print Patricia Hren / Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Crematory or other place) 1/26/201 Hanover Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor Charles L. Stevens Funeral Home, 1501 E. Fort Ave. Baltimore MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a nonsequence of) if any, requiring to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No g Unknown by signed t Part_II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 Yes 2 No 3 Probably Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas performe 1a hex this certificate 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 2 No မ 1 🗌 Inpatient 2 🔀 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Alatural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination a rose introduction, using specific process. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed ca e of death (Item 23a) (Type, Print) JAN 2 31. Date filed (Month.

DHMH 17 Rev 7/2009

State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Ronald Dean 3. Time of Death 2. Date of Death Hood Physician/ Timber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med Cen Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 49 vrc 8. Date of Birth (Month, Day, Year) 9 / 1 9 / 6 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 218-78-6324 Min. 1**X** XM 2 □ F Months Hours Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland Director MD Brooklyn 1[★] Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 E. Patapsco Ave 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 XXIII Yes, Give Year or Dates. ģ 1 Never Married XX Married White 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 Divorced 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Modern Man Modificat Owner/Proprietor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Ronald Dorothy Cantrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1942 Searles Road, Baltimore MD 21222 Robert Blades /Partner Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20c. Location - City or Town, State 1/26/2011 Hanover MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor Doda 22 Charles L. Stevens Funeral Home, Inc. Ρ. Jiw 501 E. Fort Ave, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or fixed or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence o Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မှ 1 Tes 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dáte of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending death. 1 Tes 2 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ո 24 hours a e Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address pleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

26

JAN

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	•	For State Registrar	State of Ma	ryland		tificate of L			eg. No. 2	B	Λ.	68			
Physicia /Medica		1. Decedent's Name (First, Middle, L Ronald		Jones					1	Year 2011	3. Time	of Death			
Examine Funeral Director		4a. Facility Name (If not institution, g The Johns Hopkins I 5. Social Security Number 6. 212-84-4743	Hospital Sex 7. Age	(In yrs. last	birthday) Yrs.	4b. City, Town, or Baltimore If Under 1 Year Months Days	City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04 – 10 -	Year)			e or Foreig			
D	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, T				104-10-			10d. Inside	e City Limit			
with the M sa or 28a-f be notified	Director	MD NA Baltimore 10e. Street and Number 5579 Whitby Road 21206								. Citizen of What Country?					
rs after death ", or items 2;	by Funeral	5579 Whitby Road 11. Marital Status 1 Nover Married 2 Married 1 Nover Married 2 Married 1 Nover Married 2 Married 1 Nover Married 2 Nover Mar					ispanic Origin? (Sp in, Mexican, Puerto Specify:	14. Ra	ce - Americ ick, White,	etc. Af:	rica				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed t	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 10th Grade	Education wade completed) College (1-4 or 5-1)	- 11	(Give life. £	(Give kind of work done during most of working life. DO NOT use retired)						fBusiness/Industry			
uld be file Mental Hy, irked othe tic event,	To Be (17. Father's Name (First, Middle, Las Charles	Peaker				Alma	Jean	Bag	Bagley					
and 2 shoresalth and N 27 is ma		19a. Informant's Name/Relationship Rica Bates - S			5620	ng Address (Street Sincla	ir Lane								
Pages 1 annent of He ant: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				sition (Name of natory or other place n Cem.	e) 01-	29-11	20c. Location Lanso	-					
permit. Departr Imports any inji		21. Signature of Funeral Service Usensee 22. Name and Address of Facility Wylie Funeral 638 N. Gilmor Street Baltimo 23a. Part 1. Enter the disease, or commodations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
Physician ≻/Medical		23a. Part 1. Enter the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Carolia C Due to (or as a	arre	st	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approxir Interval Onset a				
icate be executed physician and sthe burial-transit	by Physician/Medical Examine	edical Examine	edical Examine	edical Examine	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ventro (or as a	cut.seque	ce of):	llation					
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit						nysician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at t	2 Fetal de	eath 3	Ectopic pregnanc	у			ate of deliv
uires that the signed by all be detact		Part II. Other significant conditions	contributing to death but not resulting in the ur			inderlying cause gi	ven in Part I.		23e. Did tobacco use contribute to the ca			of death?			
The law requate has been page 2 shou	Completed	<u> </u>						24a. Was ar autops perform 1 Yes	v I	. Were auto prior to co death? 1 \[Yes	opsy findir ompletion 2 PNo	gs availat of cause o			
ig Physician: er this certific neral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	Hospital: 11 Inpatien 28a. Date of Injury (Month, Day)	/Outpatien Bb. Time of Injury	26. Place of Death (Check only one) ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Oth of 28c. Injury at 28d. Describe how injury occur Work?					y)					
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State)									er or Rural Route Number,				
ne Hospita in 24 hours he Funeral pletely fille	edical		Physician: To the best of aminer: On the basis of and manner state	examination								se(s)			
To the within to the common co	Ž	29b. Signature and title of certifier	1			29c. License	-000		9d. Date sign anvari	ed (Month,	Day, Year,				
State		30. Name and address of person wh DAV ID MAB 31. Date filed (Month, Day, Year)				Print) lospital	600	North Wol	fe St, B	altimo	re, MI), 212			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ JANUARY 2 2011 MATTIE B. JENNINGS 8:35 P. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A 3320 W. ROGERS AVENUE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. NEW JERSEY Days Hours 277/1930 1 □ M 2 🕅 F 80 Yrs. **Director** 223-34-3382 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 X Yes 2 No MD N/A BALTIMORE CITY 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ò must be 23a Funeral 3320 W. ROGERS AVENUE 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced BLACK Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) YEARS Elementary/Seconday (0-12) MEDICAL NURSE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ROGERS BLACK NANNIE TYNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE ANGELA J. HILL/DAUGHTER 2719 OVERLAND RD. MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State WOODLAWN CEMETERY 1/29/2011 WOODLAWN, MD 4 Donation 5 Other (Specify) THE JOHNSON FUNERAL HOME, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Lic. nsee MO1139 8521 LOCH RAVEN BLVD. 21286 TOWSON, MD 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ years preast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Date to for selection packages on To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed 1 ☐ Yes 2 ☐ No certificate ☐ Yes 2 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral (27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 🗆 Yes 2 🗆 No Natural 5 Pending injury Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of c 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 7501 Osler Drive Towson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma		artment of Health	and Mental	Hygiene	0011	01605
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	T a B-1	Reg. No.	<u> </u>	01685
	Physicia		TARMAS JAMFS			2. Date of Month		2011 Year	3. Time of Death 5:15 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	1	4c.	County of Death	1 / / /
	<u>-</u>		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year I If Under	7 24 Hrs. 8. Date of	f Dirth	N/H	ologo (State or Eamine
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Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f sho if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	9	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Numb	er or Rural Route Nu	mber, City or T	Town, State, Zip (Code)
	l and 2 s f Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date Date	20c. Loc	cation - City or To	own, State
E O	Parit in		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MEDVI)	natory or other place)	1-24-11	CATO	roulle	mV,
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signatur of Funeral Service Line psee	22	Name and Addres of Facil	TUS 120/16	DAILTON NE	1 1955 T	11229
			23a. Part 1 Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.	he death. Do not ente	er the mode of dying, such as	cardiac or respirato	ry arrest,		Approximate Interval Between
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09	certificate be executed inding physician and use as the burial-transi	dical	d						
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Division of Vital Records,	law req las bee 2 sho	nplet	Ţ.			l :	Was an autopsy	prior to co	osy findings available mpletion of cause of
8	iician: The law certificate has rector, page 2		25. Was case referred to medical				performed? Yes 2 No	death? 1 🗌 Yes	2 🗌 No
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0	ing Ph		27. Manner of Death 1 Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, 1)	Year) 28b. Time of injury	28c. Injury at work?	28d. Descr	ibe how injury		
Sior	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	/ - At home, farm, stre	M 1 ☐ Yes 2 ☐ eet, factory, office		on (Street and	Number or Rural	Route Number,
	tal or , irs after all Dire led in t		building, etc. (Specify)			Town, State)		
	To the Hospital or Attending Physician: within 24 hours after death as the Funeral Director. After this certification pleted filled in by the funeral director, it	Medical	29a. Certifier (Check Check only one) 1 Certifying Physician: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 1 Certifying Nurse Practioner: To the best of my Check on the	mination and/or invest	igation, in my opinion, death o	ccurred at the time, d	ate and place,	and due to the car	use(s) and manner stated.
	To th To th COTI		29b. Signature and title of certifier		29c. License number		29d. Date	e signed (Month, I	Day, Year)
	5 .		30. Name and address of person who completed cause of dea	th (Item 23a) (Time 1	14172721			24/11 10	an
	'5√		Kelli Eimer, 228. Gr	eene St.	Bultimore 1	UD 212	101		
ı	Stat Registra		Kelli Emer. 228. Gv. 31. Date filed (Month, Day, Year) JAN 26 2011	s Signature	parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month . A M **Physician** onald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Genesis Health Care - Perring Pkwy. Ctr Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year) Min. Months Days Hours 1**X** M 2□ F Maryland 1949 October Director 214-54-6668 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2 XNo Director Nottingham Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21236 United States 3905 Putty Hill Ave. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) truck driver construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Theresa Mary Famback Earle Ellsworth Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Johnson/brother 202A Clifford Lane Forest Hill, MD 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory [Jan. 24,201] Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John O. Mitchell IV, Funeral Services of Dulaney Valley
Tohn O. F. Bederia Pd. Timonium MD 21093 P.A 21. Signature of Funeral Service Licensee 200 E. Padonia Rd. Timonium, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatec hepatocellular cancel Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed parete physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performed? Yes 2 Divo scites 2 🗆 No 1 🗆 Yes To the Hospital or Attending Physician: 25. Was case referre o medical examiner? funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Atter this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. the ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 821 N. Eutaw St. Marcia Soulsman Baltimore, 31. Date filed (Month, Day, Year) 32 State JAN 26 racke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHN STEVEN JUSTIS 1705 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Medical Wicomia Sex 1X M 2 □ F If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 19, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months 1950 Maryland 217-54-7551 Director 60 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Anne Arundel Co. Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral 3 West Nap Lane USA 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Transportation permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Millard Swen Justis Allene Standridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 836 Ritchie Hwy, Ste 3, Severna Park, MD 21146 Kenneth Menzies (Pers. Rep.) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulaney Valley Mem. Cardens 1/28/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign And of Funded Se MITCHELL WIEDEFELD FUNERAL HOME 6500 York Road, Baltimore, Mary Martin D. Lawson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law has page 2 autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical (1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practice ner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as estated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.Greg

State Registrar 31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JORDAN Month CLAIRE 6:55 AM 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR NORTHHAMPTON FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 579-22-3919 1 M 2 X F Hours (Month, Day, Yea, 7/28/23 87 Country) Director MD Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Frederick Sabillasville 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 16910 Sabillasville Road 21780 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 6 ð 1 Never Married 2 Married 1 ☐ Yes 2 🛣 🕉 If Yes, Give 1 ☐ Yes 2 XXo Specify: "natural", Completed 3 Widowed 4X Wivorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 2 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked o ပ Edgar W. Whitman Susanna Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21780 Department of Health an Important: If item 27 is any injury or other trau Christopher 16910 Sabillasville Road, Sabillasville MD Jordan /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 1/19/2011 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) L. Stevens Funeral Home, Fort Ave, Baltimore MD 2 21. Signatura of Funeral Service Licensee Victor Charles 1501 E. Doda 1)(E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cerebro Vusculon Acciden disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Vear Pregnant at time of death signed by the a d be detached f 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pade performe this certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: As completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecritifying Physician: of the cause (s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 1-12-2011

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. P gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chand Paid, MD 801 Tolk House Ave, Frederick, MD 2170/

Please Type or Print in Black Indelible I	nk. Ensure A	II Copies Are	Legible.
State of Maryland / Department of	Health and M	lental Hygiene	

			For State Registrar	te of iviaryian		artment of Hea tificate of Dea		,,	ene eg. No.2	1 01689			
	Physicia	ın/	Decedent's Name (First, Middle, Last)	77	. 1		Date of Death Month	Day Ye					
	Medic Examin	cal	Frank Thom 4a. Facility Name (if not institution, give street ar	Thomas Keith treet and number) 4b. City, Town, or Location of Dea				JANUAR	4c. County of E	 			
	LAdilli	ici	SINAL HOSPITAL OF (E	BALTIMOR	_	f	40. County of E	No.			
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2	7. Age (In yrs. Ia	est birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Feb. 5,	Year) 9. 1942	Birthplace (State or Foreign Country) Georgia			
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits								
	Maryla 28a-f	irect	MD Baltimore			1 ☐ Yes 2 🛣 No							
	s 23a or inst be n	Funeral Director	10e. Street and Number 105 Fitz Court			10f. Zip Code 2113	36	1	0g. Citizen of What Country? U.S.A.				
21215-0036	e filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	1 Never Married 2 X Married 1 If Ye	Decedent Ever in U.S ed Forces? Yes 2 X No s, Give or Dates.	Vas Decedent of Hispar i Yes, specify Cuban, M ☐ Yes 2 X No Sp		ify Yes or No- lican, etc.)		merican Indian, /hite, etc. White				
15-(72 hou n "nath ledica	nplet	15. Decedent's Education (Specify only highest grade comp	leted)	(Give I	lent's Usual Occupation kind of work done during O NOT use retired)	n ng most of workin	g	16b. Kind of Busine	ess Industry			
212	within giene.		Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)	lite. Di	Tay1	aylor Service Co						
pu	tal Hyg d othe event,	o Be	17. Father's Name (First, Middle, Last)			18.	. Mother's Name	(First, Middle, M.	,				
ryla	should be file and Mental I is marked of raumatic eve	잍		eith				Annie	May Sho				
Ma	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print Barbara Keith Wife)	1	ig Address (Street and I itz Court			City or Town, State Maryland	Zip Code) 21136			
Baltimore, Maryland	age 1 and 2 s int of Health t: If item 27 or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova	from State	Place of Disposition (Name of cemetery, crematory or other place)		D		20c. Location - City				
Baltin	permit. Page 1 a Department of I Important: If ite any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	isterstov									
	402 4 6		23a. Part 1, Enter the disease, or complications	that clused the death	, ,	TINE FUNERA				21136 Approximate			
	Physician/ Medical		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	on each line. OG SAGGE ue to (or as a cons	Care	astric Cou				Interval Between Onset and Death			
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequ	ence of):								
	and transit	Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events c.		44								
260	cate be executed physician and s the burial-transi	ledical E	resulting in death) Last	ue to (or as a consequ	ence oij.								
Box 68	ath certifi attending for use a	≥	FFEMALE: 23c. If ye 23c.	23d. Date of Month	delivery Day Year								
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing	acco use contribut	e to the cause of death?								
ds,	quires en sig ould b	ted	Coronary ARTERY	DISEASE	, HYP	ERTENSION)	1 Ye	s 2□No 3□	Probably 4 Unknown			
Division of Vital Records,	2 2 3	Completed by						24a. Was an autopsy perform	y prior deat	autopsy findings available to completion of cause of 1? Yes 2 No			
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?			Other	of Death (Check	only one)					
of V	Phys r this eral dii	e: To	T LI Yes 2 No	1 Inpatient 2 Date of injury	ER/Outpatien 28b. Time of	t 3 DOA Other 4			nce 6 Other (S	pecify)			
on o	Attending or death. ector: After by the fune	icat	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury	work?	2 🗆 No	04. 0000.1100 1101	, many occanica				
Divisi	Hospital or Attending I 24 hours after death. Funeral Director: After eted filled in by the funer	l Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.		tion (Street and Number or Rural Route Number, or Town, State)								
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To Medical Examiner: One only one) 2 Medical Examiner: One of Certifying Nurse Practions	ne basis of examination	and/or invest	igation, in my opinion, de	eath occurred at	the time, date and	place, and due to t	he cause(s) and manner stated.			
	To the within 2 To the comple		29b. Signature and title of certifier Pora Ropraume	sing			mber - 000	29	Date signed (MODE) ANUAR 1/21/20	onth, Day, Year)			
	N		30. Name and address of person who complete NIRA ROOPNARINES				HOSPIT	er ne	BALTIM	NEF			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure Ann	Les .		11-01	<u></u>				
	Registra	ar	SIMILE O EUTI	The last	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19 January 2011 9:45 Karen P. Krywucki Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Laurel 3377 Sudlersville S. 8. Date of Birth (Month, Day, Year) Aug. 19, 1956 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days 1 DM 2 1 F Months MD 54 Director 215-70-1140 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10b. County 10a, State the Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Laurel MD 10f. Zip Code 10g, Citizen of What Country? 0 10e. Street and Number Funeral 23a USA 20724 3377 Sudlersville S items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 0 1 Never Married 2X Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 22XNo If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Assistant 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Shirley Heishman Sherman S. Pruett other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a 3377 Sudlersville S., Laurel, MD 20724 Thomas J. Krywucki/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o of January 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 2011 Crownsville, MD 4 Donation 5 Other (Specify) Veterans Cemetery MD 22. Name and Address of Facility Donal son Funeral Home, P.A. Signature of Funeral Service Licensee Kentile 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ęnysician/ Glioblastoma multiforme disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 - Fetal death 3 Day in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Month Year Pregnant at time of death Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🛭 No 2 🛣 No 1 🗌 Yes certificate Yes filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) after death.

Director: After this 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 🛚 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 19, 2011 D035067 luamaniam

DHMH 17 Rev 7/2009

State

Registrar

A Calland

Deepa Subramaniam, MD, 3800 Reservoir Rd., Washington, DC 20007

32. Registrar's Signature

LARBORA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c,e,f per fh g911 1-26-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 20°1°1 01:18 AM KARLIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 504 SUMMERVALE COURT HARFORD BEL AIR 9. Birthplace (State or Foreign Country) NY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Min. 1 □ M 2 🗓 F Hours 1170971930 80 Yrs Director 114-22-4847 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland NJ . 10b. Monmouth 10c. City, Town or Location **Oakhurst** 10d. Inside City Limits Director 1 Yes 2 No MD-HARFORD BEL AIR Street and Number 603 Dinsmore Place 10f. Zip Code 10g. Citizen of What Country? Funeral SUMMERVALE COURT 21014 07755 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Completed 3 X Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CHARLES BERNSTEIN PAULINE LINDENAUER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WENDY DRABINSKI / DAUGHTER 504 SUMMERVALE COURT, BEL AIR, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL CEMETERY 01/24/2011 BETH WOODBRIDGE, NJ 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Dent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Dhable disease or condition resulting in death) Pancicati months Medical Due to (or as a consequen a of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ Wo Month Day Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by metastases 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, i 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 31. Date filed (Month, Day, Year, 32. Registrar's Signature State **JAN 26** Registrar

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23b per doc golf 1-26-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar 0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) JANUARY 23, 20 l'I 9:00 AM Physician/ KNOPF ROSE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner ANNE ARUNDEL PASADENA OAK LODGE ASSISTED LIVING 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Days Country) Funeral Min Hours 1170871913 1 - M 2 K F Months PA 97 Director 164-09-6640 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No 28a-f ANNE ARUNDEL **PASADENA** MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe ò 23a Funeral USA 21122 1093 HOLMESPUN DRIVE "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates WHITE 3 KWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** ART TEACHER 5+ 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) MANKIN 2 ANNA JOSEPH **BRODY** permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1093 HOLMESPUN DRIVE, PASADENA, MD ANDREA MELNICK/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3X Removal from State SPRINGFIELD, PA 01/25/2011 SHARON CEMETERY MT. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Li 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Onge disease or condition resulting in death) Medical Due to (r as a consequence of): 5 years Examiner Coronary Atery Disease Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dies to for as a consequence of; ng physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery nse 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months2

1 Yes 2 10 5 Other (specify) jo Pregnant at time of death Unknown as been signed by the a g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ 🎾 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificate har funeral director, page 1 Yes Yes 21 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes 욘 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury work Natural 5 Pending 1 Yes 2 No 124 hours after Lowers a Funeral Director: Af ☐ Accident ☐ Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (Check and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Betty Krofka Month 1/19 Physician/ /201 2:12pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Yea | 6 / 1 2 / 2 4 Social Security Number 110-14-5082 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Country) 86 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1 Xes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2X No Yes, Give Maryland 21215-0036 1 Yes 2XXNo Specify: White Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Oliver 17. Father's Name (First, Middle, Last) Ford Peterson မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8505 Newark Rd, Newark MD 21841 William Krofka/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation XXRemoval from State Maple Grove Cem. 1/26/11 Frewsburg, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor Doda Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore Inc MD21230 010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between PNEUMONIA Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing many sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 - No 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Acciden
☐ Suicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certiffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 00062172 1/19/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

SHARAD

31. Date filed (Month, Day, Year)

R SATYAL, MD

1604 MARKET ST.

MO

POLOMOKE CITY

21851

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 14 Day Physician/ Month 201^{Year} 1735 p ^M Peggy Jean Lampkin Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly 5 Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Month Day, Year) 36 1 M 2 X Months Days Hours Min. 74 VA **Director** 577-54-7077 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Riverdale 1 ₹ Yes 2 □ No Prince George's MD 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ms 23a or Funeral **Black** 20737 6311 Riverdale Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or iter edical Examiner Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene.
Ad other tha than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic even မ Lee Davis Bennie Davis Amie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6311 Riverdale Rd. Riverdale, Wise V. Lampkin/Husband MD 20737 Department of Health
Important: If item 2
any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Quantico National Cem 01/24/2011 Triangle, VA 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service License mi 4217 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death h sician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Acidosis Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying ner Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 X No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 🖺 Natural 5 Pending 1 Yes 2 No the 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: 70 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

HOSPITAL DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEFHANE

2011

31. Date filed (Month, Day, Year,

JAN 26

55 703

CHEVELLY, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OBERT JANUARY 16:57 PM LIESKE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE TOHNS HOPKINS BAYVIEW MEDICAL CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X**XM 2 □ F Days Hours (Month, Day, Year) 02/01/1932 Mary land 213-28-8811 Director 78 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 XNo Maryland Harford Bel Air ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2215 Calvary Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1955-If Yes, Give Year or Dates. 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc þ 1 Never Married 2 X Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Civil Servie US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even onee. and Mental His marked of မ Ruth Elsner Frederick Lieske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie L. Lieske (wife) 2215 Calvary Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2011 Aberdeen, Maryland Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 22. Name and Address of Facility Weng Aberdeen, 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician/ ISCHEMIC STROKE WITH HERNIATION disease or condition Medical resulting in death) Examiner FIBRIL UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 nding _L se as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No Yes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Matural work?
1 Yes 2 No n 24 hours after death e Funeral Director: A bleted filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifie

State Registrar mes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DWEGI

26

32. Registrar's Signature

RES - 000

29d, Date signed (Month, Day, Year)

EASTERN AVENUE, BALTIMORE, M.D. 21224

JANUARY 24, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G912 2/01/2011 JH state of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2011 January Howard Massenburg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

9. Birthplace (State or Foreign Country) Towson

If Under 1 Year | If Under 24 Hrs. Manor Care Nursing Home 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Hours Months Days 1 □**y**M 2 □ F 76 12 08 34 NC Director 213-32-3299 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be r Funeral 2409 West Street 21216 U.S.A. 14. Race - American Indian, Mosher 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Cab Driver Royal Cab Company permit. Pages 1 and 2 should be filed. Department of health and Mental High. Important: If item 27 is marked any injury or other to once. 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Be Fayte Massenburg P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace Massenburg-Wife 2409 West Mosher Ave, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Ukn 20c. Location - City or Town, State Owings Mills, MD 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Baltimore, Md 4 □ Donation 5 □ Other (Specify) 2/08/2011 | 22.Name and Address of Facility MarchF/H West 4300 Wabash Ave, Baltimore, Md 21215 21. Signe ture of Funeral Service Ligenses 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or headfailure. List only one cause on each line. Approximate Interval Between Onset and Death Accident Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular Physician week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 28a. Date of Injury (Month, Day Year) neral Director; After the filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; Division 1 Natural 2 Accident or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after the Hospital To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

JAN 26 2011

Medical

of death (Item 3a) (Type, Print)

8

29c. License number

29d. Date signed (Month, Day, Year)

Towson, MD 2011.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 08715 0 2011 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1⊠M 2□ F Yrs 577-78-9312 53 Director 06/22/1957 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. In: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Yes 2□No Director MD Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5105 Emo Street 20743 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private College (1-4or 5+) Elementary/Secondary (0-12) Engineer years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Benjamin Franklin McCalip Merline Dent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Latesha McCalip/Daughter 819 Booker Place Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Important: If Its any injury or o Burial 2 Cremation 3 Removal from State Glenwood Cemetery 1/29/11 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CANCE Examiner Due to (or as a consequence of) Physician/Medical Examiner the burial-transit or Attanding Physician: The law requires that the death certificeta ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the pege 2 should be detached 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings Be Completed 24a. Was an autopsy performed? available prior to completion of cause of death? 2 NO 1 ☐ Yes 2 No 1 🗆 Yes After this cartificate within 24 hours after deeth.

To the Funaral Director: After this cartifice completaly filled in by the funeral diractor. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 TYes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours as To the Funaral D No Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 68294 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) hoophilus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26 2011 Registrar

ORIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 33 Month MARY MURGATRUYD 3011 anually 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) timore otting | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 1 🗆 M 2 🗾 F 8 Months 219-18-0913 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No MID Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 12. 11. Marital Status Armed Forces?

1 Z Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes. Give 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) tome 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) City or Town, State Method of Disposition Date UNK 20c. Location -1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature an un al Service Lice 22. Name and Addr - of Facility 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzheimer Immediate Cause (Final years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery 23b. Was decedent pregnant

Physician/ Medical Examiner

Physician/

Medical

10a. State

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Funeral

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Examiner

Funeral

Director

28a-f show

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the Medical Examiner must be notified

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permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me

injury or other

any

within 72 hours after death

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760

Division of Vital

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the furneral director, page 2 should be detached for use as the burial-transit Physician/Medical signed by the sid be detached f þ Completed Be ျ Certificate:

Natural

☐ Accident

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 PUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

7444

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

2011

21284

State Registrar

Medical

1exander 31. Date filed (Month, Day, Year)

26

Investigation 6 Could not be

determined

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 Physician/ January 201 3:15PM Lloyd W. Moyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7854 St. Fabian Lane Dundalk If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 1-26-1932 1 🔀 M 2 🗆 F 215-28-6643 78 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Dundalk 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 0 10e. Street and Number 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be Funeral 21222 USA 7854 St. Fabian Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Printing 12 Printer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pe. Agnes Gatebach permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Harvey Moyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Moyer - Wife 7854 St. Fabian Ln., Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Carcemation 3 Removal from State 1-26-10 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No **Division of Vital** 25. Was case referred to predica 26. Place of Death (Check only one) Be examiner? 2 No 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

0

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink 2 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No-3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day William **Physician** SUN 2011 anuary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country)
 MA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 018-34-3644 Tay 13 1 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ✓ Yes 2 ☐ No Directo Ellicott Howar 10g. Citizen of What Country? 10e. Street and Numbe 7809 21043 USA Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than ea AHORNE 13 Department of Health and Mental Limportant: If them 27 is many injury or other. 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son Christopher 20a. Method of Disposition Ellicott 7809 ane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Alleritown, PA 4 Donation 5 ☐ Other (Specify) eenwoo Crementon 21. Signature of Fund Solice License 22. Name and Address of Facility 18434 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or se (Final Mid-valley Approximate Interval Between Onset and Death 23a. Part 1. Enterd Immediate use (Final disease or ondition resulting in death) **Physician** Subdurak /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed burial-tran and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 □ No P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 2 No 1 Yes 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 9:05 AM fell down stairs 1 Natural 5 Pending 1/13/2011 1 🗌 Yes 2 X No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide or A after 1209 South Potomac St. Baltimore MC 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in the property of the pasts of examination and/or investigation. the Hospital 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Frattalone (M) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Backs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		For		State of	of Mary	yland /	Depa	rtment of	Health	and M	iental Hy	/gien	е			
		StateRegistrar					Cen	tificate of	Death			Reg. N	lo. 0	ţ .	0 1 7	21
Physicia	n/	1. Decedent's Name		•							2. Date of Do)ay	Year_	3 Jime of D	
Medic	al	Mattie					1		1 1	(D 4)	01	12		Year 11	0413	Ам
Examin	er			give street and nun	nber)		4b. City, Town, Rockvi		n of Death			c. County o				
Funeral		Shady Gr 5. Social Security N		yrs. last bi	irthday)	If Under 1 Yea	r If Unde	er 24 Hrs.	8. Date of Bi	irth	Montgo	9. Birthp	lace (State or F	oreign		
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or 28	Dire	MD 10e. Street and Nur	Montgo	omery		Silve	er Sp	10f. Zip Code				10a. C	Citizen of Wh	nat Coun		
with th	eral	1422 Mor	ninggi	de Drive				20904					USA			
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72 hc in "na Medic	nple		cify only highe	nt's Education est grade completed,		- 10:	(Give k	ent's Usual Occ ind of work don NOT use retire	e during mo	ost of worki	ng	166.	Kind of Bus	iness Ind	dustry	
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ld be Ment arked atic e	မ	John Br	own						Sa1	lie E	lizabe	th I	Daniel	.s		
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and 2 Health em 2 ther t		Annie L. 20a, Method of Disr		Daughter				ornings	ide D		ver Sp	_	Location - C		_	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XBurial 2	☐ Cremation	3 Removal from	State	cemet	tery, crem	atory or other p					entwo	Ť.,		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a redecti. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ate	1 🔀 Natural	5 🗌 Pendir	9	of injury oth, Day, Ye		. Time of injury		uryat ork? □Yes 2		28d. Describe	how inju	ury occurred	1		
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DHMH 17 Rev 7/2009

MATTIE FORCH JANUARY 14, 2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician Month 2011 lan /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Keswick Baltimore
Under 1 Year If Under 24 Hrs. are 8. Date of Birth

Month, Day, Year)

25, 1923 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 214-20-0269 Usual Residence of Decedent 1 ☐ M 2 🔀 F Director filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or itema 23a or 28a-f sho other traumatic event, the Madical Examinar must be notified at 1 XYes 2 □ No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ ucator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should I nent of Health and Meni ၉ George evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) item 27 i Jon 5103 Baltwore lan Powson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it is eny injury or o 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison of Funeral Service Licensee 21. Signati aughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTAGE DEMENNA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes 2 ☐ No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Working Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, Seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mm nmo Amuary 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 IWY on m.T. north 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

26

Registrar

parker

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 29d per dvr g911 1-26-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANNELIESE JANUARY 22 Day 2011 Year ROGERS 8:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH AND REHABILITATION FOREST HILI 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
Germany **Funeral** 7. Age (In vrs. last birthday) 1 🗆 M 2 🛛 F Months Days Hours Min 03/19/1924 Director 213-60-4028 86 Usual Residence of Deceden 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ex Yes 2 No Maryland Harford Aberdeen ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 131 Darlington Avenue 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed with and Mental Hygier 7 is marked other ti Home maker In Home Be 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည nknown nown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1206 Main Street, Darlington, MD 21034 Linda S. Bruder (friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 D Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2011 West Chester, PA Ferris & Company 21. Signature of Funeral Service dicenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Due to or as a consequence of) Cer Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of imjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Dialutz 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director; β completed filled in by the f Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ,O Dund 5 Din D32295 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DAVID DUNN -615 W. MACPHAIL ROAD BEL AIR MD. 21014 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00526 State of Maryland / Department of Health and Mental Hygiene Alonzo Reddicks 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 19, 2011 0936 hrs **Medical Examiner** Reddicks Charles 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 701 Sheridan Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Country) MD 49 10 30 219-50-0040 1 X M 2 F 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a. State 1 X Yes 2 No 28a-f show NA Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 701 Sheridan Ave 21212 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1X Never Married 2 Married 2X No Ves Black 1 Yes 2X No specify: Specify: 3 Widowed 4 Divorced If Yes, Give Year l other than "natural", the Medical Examiner Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene.
Important: If item 27 is marked other than injury or other traumatic event, the Medic Office US Coast Guard 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alease Wilson Charles Reddicks
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alease Reddicks-Mother
20a. Method of Disposition 3018 Woodland Ave. Baltimore Md 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/26/2011 Owings Mills, Garrison Forest 4 Donation 5 Other Specify. 21 Signature of Funeral Service License 22. Name and Address of Facility March F/H West |4300 Wabash Aye, Baltimore, Md Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a.pt.II,27 per me g912 2-2-11 vt X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ፩ Cirrhosis of the Liver Completed After this certificate has been a funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 Yes 2 No e Hospital or Attending Physician: Tl 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) To the Hospital
within 24 hours a:
To the Funeral I determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year) **JAN 2 6 2011**

ORIGINAL

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 20, 2011

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHMONI TANLEY 10:50AM 2011 Oi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE 6. Sex 1-2₹ M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1071271928 **Director** 216-24-6216 82 MD Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6612 WICKFIELD ROAD 21209 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 AGENT INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I item 27 is marked o MORRIS RICHMOND DORA BLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHODA RICHMOND/WIFE 6612 WICKFIELD ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 01/25/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC Onset and Death MERKEL CELL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2. No 1 Yes 2 No Yes Be (25. Was case referred to medical **Division of Vital** ours after death.

neral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number MYSICIAN 130064533 01-24-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LCVN SALE NEBREW CICHATRIC CTAL. 2434 W. BELVEDERE AVE BOTTIMOSE, MI) 21215 BABATUNDE M- AJANI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JAN 26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2011 LILLIAN ROSENZWEIG 4:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD VANTAGE HOUSE COLUMBIA 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F Hours 0471971919 **Director** 199-05-5244 91 PA Usual Residence of Decedent 3a or 28a-f show the notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HOWARD 1 Yes 2 No COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Examiner must 8607 VAST ROSE DRIVE 21045 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 24 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 □ Divorced If Yes. Give Specify: Completed WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work dane during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ WEINSTEIN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic SAMUEL MARGARET BERKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA BER/DAUGHTER 8607 VAST ROSE DRIVE, COLUMBIA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DALTON JEWISH CEM. 01/27/2011 DALTON, PA Funeral Service 21. Signature 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KELEI Failure Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Astuniuslutic Vascila Diserca Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) pec 9 Unknown signed by the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2-No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? page 2 autopsy certificate 1 Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify After this To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) der (que

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

26

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ OUSS AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 2 M 2 - F Months Hours Min. (Month, Day, Year, Director 19-ASHING FON DR Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 ☐ No timore MARYLAND 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral 2122 3529 Gough 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Kyes 2 No Victuan Black. White, etc., ð 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Are Force 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Hyundi =ox other traumatic event, the 2+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SHAPIRO unia ည LENA Just 1 and 2 sho Just 2 should be alth and important: If item 27 is many injury or other? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3529 41to Shapiro-spouse Cooks 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Odenton 1-25-2011 inlest 4 Donation 5 Other (Specify) 21. Signat 22. Name and Address of Facility Funeral Service Licenses OSEPL complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or hard failure, Lis Interval Between Immedi ause (Final dis or condition Onset nd Death creas Physician/ Carcinoma Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached to g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 👿 No 1 🗌 Yes ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o the Ho within 2 To th 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roven Boylevard Baltimore, Maryland 21218 3900 Loch John S. Lah, m.D 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #27, 28a-1, per me, g952 6-2-14 SM State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2347 **Physician** SILAS L. SMITH /Medical 4a, Facility Name (If not institution, give street and number) 4b. Oity, Town, or Location of Death 4c. County of Death Examiner Ugnes Heal ('ave N/A Sex XXM 2□ F If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 53 OCT. 7 1957 VIRGÍNIA Director 251-06-3723 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location show r items 23a or 28a-f shov increust be notified at Director 1 XYes 2 ☐ No MARYLAND BALTIMORE N/A the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2675 FREDRICK AVENUE 21223 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, I'm Modical Exercitance. 1 ☐ Yes XXNo Specify Specify BLACK þ 3 Widowed XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ROOFER CONSTRUCTION 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES S. SMITH ပ WILHEMINA BUTTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sedrik Smith/Son 1000 Duwnton Rd., Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 🔑 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ZION CEMETERY 01-29-2011 LANSDOWNE, MARYLAND 22. Name and Address MILLERS ME 1639 N. BR fress of Facility METROPOLITAN BROADWAY 21. Signature of Funeral Service Licens CHAPELS 23a Part 1. Enter the disease shock, or beart failure. e or complications that caused the death. Do not enter the mode of dying, List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): EXAMINER CERTIFICATION APPROVED BY MEDIC law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: signed by the attendin yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of deatly? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>\$</u> 2 No 3 Probably 4 🖫 Unknown 1 ☐ Yes Atter this certificate has been stuneral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 FER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation allergic reaction to medication(lisinopril) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2675 Frederick Ave. death. 1 ☐ Yes 2 😿 No 2 Accident 1/23/2011 fd11:00p^M To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Home Baltimore, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN-SEAN A. MCGANN, DO Baltimore, MD 400 31. Date filed (Month, Day, Year) **Begistrar's Signature** 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMES SKOLASKI, SR Physician/ BENEDICT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TRANSITIONS KESVILLE CARROLL HEALTHCARE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 - F 79 Days (Month, Day, Months Hours Min. WISCONSIN 398 26 Director Usual Residence of Decedent or 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director CARROLL SYKESVILLE 1 Yes 2 No MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1970þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Z Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 1954 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) MARKETING CHEURON USA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 JOSEPH SKOLASKI MARGARET BENJAMIN ELIZAGETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GOOD PINYON PINECOURT EZDERSBURG-MO 21784 JAMES B. SKOLASKINA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State . Page 1 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 127/2011 South CARROll Crem WINFIELD, MO JNZUMBRUN FIT & MONCO. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility rembrun 6028 SYKESVILLE RO ELDERSBURG-MO 21784 23a. Part 1. Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 42 hours affer death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 100 ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 🛂 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signat 29d. Date signed (Month, Day, Year) 01-26-2011 0054218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (DR. RAMAN B. Kanena) West minth MD 2/1177 Mal calm duk ▲2 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 201 9

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Voor Month Lucille Smith Mabel Medical 0119 201 2:18p 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 4500 Belvieu Ave Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 09 21 1 □ M 2 🕱 F Days Hours Country) Director 83 217-24-7873 MD Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No MD NA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 4500 Belvieu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No ģ 1 Never Married 2 Married 1 Yes 2 No Specify Black Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Public School Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Educator System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Wharton Sr. Ethel Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4500 Belvieu Ave, Baltimore, Md 21215 Neva Camp-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site 1/27/2011 Baltimore, Signature of Feneral Service Licenses 22. Name and Address of March F/H 4300 Wabas West Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ month Medical resulting in death) Examiner Kidher 2 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Scleros and-tran attending physician for use as the burial Physician/Medical Stenosis IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و و Mber hara thursides in 1 Yes 2 No 3 Probably 4 Unknown Completed abdominal dortic a neury in 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes 2 XNC 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔼 No 유 1 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation in by the I Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours a Funeral L

29a. Certifier

Medical Defitying righting to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 3212 2011 MC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 MD 21228 31. Date filed (Month, Day, Year) State 26 Registrar DHMH 17 Rev 7/2009

1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. WAYNE A. SWEENEY 2011 7:29 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEAKE HOSPITAL BELAIR HARFORD Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 03/28/195 213-70-4708 Director 55 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD. HARFORD **EDGEWOOD** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be 826 OLIVE BRANCH CT. UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify. Completed 3 Widowed 4 Divorced . Page 1 and 2 should be filed within 72 hour trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natu jury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 CDL TRUCK DRIVER SCHAFFER/CREIGHT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HOWARD SWEENEY HELEN MACDONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE SWEENY/WIFE 826 OLIVE BRANCH CT., EDGEWOOD, MARYLAND 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XI Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ATLANTIC CREMATORY 01/22/2011 4 Donation 5 Other (Specify) GLEN BURNIE, MARYLAND 21. Signature of Fineral Service Licens 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Rart : Enter the essease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Metastatic Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying SWEEREY, Wayne P.O. Box 68760 Physician/Medical Examiner Due to (or as a consequence or, Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I only d 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signata ٥ m. D. D 45390 who completed cause of death (Item 23a) (Type, Print)
1. D. 602 South Akwood Road # 200, Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Payton Elizabeth Spann 2011 7:11 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth . Age (In yrs. last birthday, **Funeral** Days 1 🗆 M 2 🛛 F Months Hours Min. Jan 21, Year) Mary I and **Director** none Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State Director 1 🗓 Yes 2 🗌 No Prince George Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 609 Laurel Avenue 20707 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 X Never Married 2 ☐ Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other th none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Nikki Annette Dull Michael David Spann, Jr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Laurel Avenue, Laurel, Maryland 20707 Nikki A. Dull Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory Jan 25, 11 Odenton, Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Laurel Maryland 20707-4389 Ave. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death).

Extremensulting in death. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 38 hrs Priysician/ Extreme Prematurity Medical resulting in death) Due to (or as a consequence of): Examiner 38 hrs Pulmonary Hemorrhage Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of sician and burial-transit 38 hrs Cause (Disease or iinjury that initiated events resulting in death) Last Tension Pneumonthorax Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🛛 No 욘 1 X Inpatient 2 - ER/Outpatient 3 - DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 💹 Natural 5 Pending M 1 Yes 2 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Neowater Attending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EESAY. 1500 Forest Glen Road. Silver Spining. MD. 20910 31. Date filed (Month, Day, Year) State 26 park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 911 1-26-11 vt. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 11.45AM SHIRLEY STEINER 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALICE MANOR NURSING HOME BALTIMORE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🗓 F Hours Months 0171071917 215-44-1991 -II- 94 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoe. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2xxNo BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Completed by Funeral 21208 10 POMONA SOUTH. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 XWidowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) BOOKKEEPER SPORTS & FITNESS 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ MOSKOWITZ **ESTHER** HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12110 VELVET HILL DRIVE, OWINGS MILLS, MD 21117 EILEEN SNYDER/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 01/25/2011 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK 22. Name and Address of Facility . Signature of Funeral Service Logisee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN_ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one bause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a c sequence of): disease or condition resulting in death) Medical Examiner emente Sequentially list conditions. Examine if any, leading to immediate cause. Liner Unidentity Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a densequence of resulting in death) Last physician Diseans Physician/Medical Com Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months Month Year Day Pregnant at time of death 2 100 ed by the a detached t g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by Joh 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 VN0 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year, MD 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE MD 21201 SHMI MD 821 N. EUTAW ST Sulte 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1,4b per doc g911 1-26-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year SENKER Mark A. Senker 1054 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITTAL OID CT. RD RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 □ F Yrs Director 219-42-0153 66 10/06/1944 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 21 is marked other than "natural", or items 23a or 28a-f show ritem 72 her traumatic event, Ita Medical Examine man be nothed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f shov ilner must be notified at Funeral Director MD BALTIMORE 1 ☐ Yes 2 No REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 CANTATA COURT, # 202 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗙 No Specify: WHITE Be Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should b Iment of Health and Menti Iant: If item 27 Is marked 2 SAMUEL SENKER BEVERLY KLEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 CANTATA COURT, #202, CHERYL SENKER/WIFE REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of OHR KNESSETH TSRA ANSHE SFARD CEM 20a. Method of Disposition 20c. Location - City or Town, State ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Manager In It any Injury or once. 4 Donation 5 Dother (Specify) 01/24/2011 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 译 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 Court 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26 Registrar

11-00303 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael P. Schneider State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day January 10, 2011 Schneider Michael Year **Medical Examiner** 2305 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River **Baltimore County** 5814 Ebenezer Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 5. Social Security Number 124-60-8569 **Funeral** Foreign Country) Min. Hours Months Davs Director 9/26/75 35 NY 1 X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Branchville NJ Sussex 1 Yes 2 No or 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 07826 118 Ridge Road USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Navy 1 X Never Married 2 Married XX Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Fleath and Mental Hygiene.
Important: If item 27 is marked other than ",
injury or other transmite even; the Medical: B filed within 72 h al Hygiene. Construction Worker Building 12 O 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Linda Lippert George Schneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 118 Ridge Road, Branchville NJ 07826 19a. Informant's Name/Relationship (Type, Print) 07826 George Schneider/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State H.G. Smith Crematory 1/17/ 1 Stroudsburgh, 4 Donation 5 Other Specify 21. Signature of Funeral Service LicenseeVictor P. Doda Charles L. Stevens Funeral Home, 1501 E. Fort Ave, Baltimore MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medical Death Combined Drug Intoxication (Heroin and Oxycodone) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit edical AMENDED 23a,27, 28a-f per me g913 3-2-11 vt X UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been I director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 X No 5 Pending the fd 1-10-11 fd 11:00pm Director: unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5814 Ebenezer Rd. Middle River, Md. 21220 filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide or Town, State) 581. Middle River, within 24 hours a To the Funeral I determined residence (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

State

Registrar

IAN 26 DHMH 17 Rev 1/2001 OCMF 2006

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

29c. License numbe

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 11, 2011

Director 217-74-7087 53 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show MD Baltimore Directo 10f. Zip Code 21215 10e. Street and Number 3915 Callaway Ave; Apt 302 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 11. Marital Status tx□Yes 2□No 1976− If Yes, Give Year or Dates: 1976 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Un (Give kind of work done during most of life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Baltimore City Police Dept 601 E. Fayette St; 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State in state **Bayview Crematory** 1-4 ☐ Donation 5 23 Other (Specify) 21. Signature of uneral Service Licensee Ronald S. Wade, 22 Harry Apdress C1 Facility Director 655 W. Baltimo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, in heart failure. List only one cause on each line. Immediate Can e (Final disease or condition resulting in death) **Physician** bleeding pper /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pertension page Schizophrenia Be 25. Was case referred to medical examiner? 26. Place of Other: 4 \(\text{Nursi Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of . Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No Director: /

3 ☐ Suicide

29a, Certifier

Sungyon

4 Homicide

29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

William F. Tennessee

4a. Facility Name (If not institution, give street and number)

3915 Callaway Avenue; Apt 302

Physician

/Medical

Examiner

Funeral

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State Registrar

within 24 hours a

Medical

North Greene 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 24, 2017 GARRISH TODD 9:00P ALICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Essex Baltimore Riverview Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XX Months Days Hours Min b9%%%%% 212-03-4372 Director 104 Virginia Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medi-al Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Tes 2 XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1708 Oakfield Avenue 21221 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S Was Deces? Armed Forces? ¹ ☐ Yes 2 🛣 No 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည int of Health and Menta t: If item 27 is marked or other traumatic e Charles David Garrish Teresa Hoffman Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen G Gunzelman Nephew 1708 Oakfield Avenue Middle River, Maryland 21221 Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o' 1)XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Most Holy Redeemer Cem. 01/28/2011 her (Specify) |Baltimore, Maryland 22. Name and Address of Fa Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or comp shock, or heart failure. List only or ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complic Interval Between mediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Lisease or impury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner's 2 No Other: မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

State Registrar 29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day,

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Year)

who completed cause of death (Item 23a) (Type, Print)

29c. License number

Mace Ave.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5.33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BA LTIMORE N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Min 1070371923 87 Maryland Director 216 16 6605 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Anne Arundel **Baltimore** Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 4 Seward Avenue 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 X Yes 2 □ No If Yes, Give Year or Dates. W Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced WW II White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. College (1-4 or 5+) 2 Years Elementary/Seconday (0-12) Stationery Engineer Proctor & Gamble Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Utz Elsie Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Utz / Wife 4 Seward Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01/28/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Baltimore, Maryland 21225 Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ULMONAR houp c Medical Due to (or as a consequence of) Examiner CONE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Records, P.O. Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) Hospital 2 No Other: ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who

completed cause of death (Item 23a) (Type, Print)

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State Registrar 29b. Signature and title of

30. Name and address o

31. Date filed (Month, Day,

6701

erson who completed cause of death (Item 23a) (Type, Print)

W

CHARLES

29c. License number

JUN NOUND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 030 Physician/ Month Medical 4a. Facility Name (it not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medica U5011 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Rirth -30-209 1 M 2 Davs Hours 3 26 ay Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No 10e, Street and Number Apt. 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 USA death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 Mo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during n life.IDO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) onday (0-12) touse Be 18. Mother's Name (First, Middle should be wanson Page 1 and 2 21207 20a. Method of Disposition 20b. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death சிரு<mark>வ்ப</mark>்கார disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the bunial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Day Year Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospita Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ninsohn 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Wilson, Evelyn # 917814

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Webster 946 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltmore Bon Secours Baltmore If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 30-1 M 2 □ F Months Min. Director Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland rartment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1-Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral d 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 189 Mother's Name First, Middle, Maiden Surname) ဂ Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of P Important: If ite any injury or ot once. 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Home સાગ્ય9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Immediate cause (Final Onset and Death Physician/ Necrotic intarcied distal small bowel and right colon disease or condition Medical resulting in death) Due to (or as a consequence of) . Examiner Esque tally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deach.

To the Funeral Director After this certificate has been signed by the attending physician and diabetes uncontrolled Mellitus been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examinar? Hospital: Other: 2 🗌 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier tem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY WETZEL 2011 BETTY Medical 11:28 PM Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL Social Security Number 7. Age (In yrs. last birthdav) If Under 24 Hrs. Hours Min. If Under 8. Date of Birth Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days **Director** 220-22-5058 81 MD Usual Residence of Decedent If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD CARROLL MANCHESTER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2319 NEVADA DRIVE 21102 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes, Give Year or Dates Specify: WHITE Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should re fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ HERMAN CHASEN MADELINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN WETZEL / DAUGHTER NEVADA DRIVE, MANCHESTER, MD 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 01/25/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physicianz ULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? jo Pregnant at time of death Unknown Month signed by the a d be detached f 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 욘 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🔲 29b. Signature and title of sertifier 29c. License number 00059552 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700A POOLE RD LESTMINSTER COUR ISHAME mo 21157 MAGANIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day **Physician** : 35 Stanley 1 Wellers 23 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (It not institution, give street and number) **Examiner** N/A 1205 Cooksie Street Baltimore 8. Date of Birth (Month, Day, Year) 2/11/45 6. Sex 1. M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 212-44-1552 65 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprising the muffled at once. N/A Baltimore MD ¥E¥es 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1205 Cooksie Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2XXIO Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 🗶 🗙 No Specify. White ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wetters, Sr. Hedwig Ida Lonczynski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley M. Wetters, Jr./Son 1205 Cooksie Street, Baltimore MD 21230 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 1/28/11 Glen Haven Cem. Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens FuneralHome,
1501 E. Fort Ave, Baltimore MD 21. Streature of Funeral Service LicenseeVictor P. Doda 2†230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) months **Physician** Corticopasilar Degeneration /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) o 1 ☐ Yes 2 ☐ No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0070688

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DHMH 17 Rev 1/2001

State

Registrar

Jennifer

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31. Date filed (Month, Day,

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Baltimure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 201 Januan Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ake wo mone a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 83 Hours Min 1 □**X**M 2 □ F Director 247-32-9076 Usual Residence of Decedent shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho inry or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 N. Lakewood Ave 21205 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, African 1 🖾 Yes 2 🗆 No 1945 If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 Divorced Amer. Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Masonary Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles Young Willie Virginia Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dierdre Young-Randall/Daug 833 N. Lakewood Ave, Balt., MD 21205 Important: If item any injury or othe 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place)
Garrison Forest V 1/31/11 1 KBurial 2 Cremation 3 Removal from State Owings Mills, Mo 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Fireral Service License 5126 Belair Rd,Balt.,MD <u>21206-5105</u> 23a. Part f: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician SMAII Cell disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death the 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has autonsy filled in by the funeral director, page death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) 10 North Greene Street State JAN 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Jacquelyn L. Ziegler 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square 5. Social Security Number Haspita Center sed al If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F Director 216-58-2018 59 10 - 8 - 1951Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ira Madical Event for most be malified at appear. 10a. State 10h County 10d. Inside City Limits 1 ☐ Yes 21 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9903 Tailspin Lane, Apt. L 21220 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ziegler ၉ Mary Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Kenneth Sheehan - Son 9903 Tailspin Ln., Apt. L. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1-27-11 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Day Myocardie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be execut⊕c attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate ! 1 ☐Yes 2 No 1 🗆 Yes 2 □No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospita. ... within 24 hours after death.

To the Funeral Director: After manetely filled in by the fur 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January, 22,2011 30. Name and addles, of perso (who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Morten FronIclin 31. Date filed (Month, Year) 32. Registrar's Signature State 6 2 Registrar

DHMH 17 Rev 1/2001

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		-	Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1							011	01726	
	Physicia	n/	1. Decedent's Name (First, Middle, La							2. Date of Death 3. Time of		
and a	Medic	al	ALFRED	MACGA	OF				24		0 201	5159AM
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	Funeral		5. Social Security Number 6. S		(In yrs. last birthda)		1 Year If L	Inder 24 Hrs. ours Min.	8. Date of Bi	rth ay, Yea <i>r)</i> 0 - 193	9. Bir	thplace (State or Foreign ountry) N. C.
	Director		240 -42 - 4770 Usual Residence of Decedent		79 Yrs.				11-1	<u>0 - 193</u>	3/	14.6.
	yland -f sho	ctor	10a. State 10b. County		10c. City, Town or							10d. Inside City Limits
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	s 23a o	Funeral Director	9529 R199	s RD				783		9	USF	
	death r item iner m		11. Marital Status	12. Was Decedent Ev Armed Forces?		3. Was Deced	ent of Hispan ify Cuban, Me	ic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	- 14	4. Race - Ame Black, Whit	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 X Yes 2 N If Yes, Give Year or Dates.		1 🗌 Yes 🛭	2 🕱 No Sp	ecify:		S	pecify: BL	ACK
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Maryland	ould be filed within 72 hours afti of Mental Hygiene. marked other than "natural", matic event, the Medical Exar	입		ORG BENY		-		UANIT		RAHAI		
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ore,	of Head of Head Hitem		20a. Method of Disposition 1 A Burial 2 Cremation 3		20b. Place of Dis		ne of ther place)		Date	20c. Loc	ation - City or	
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			23a. P. 1. Enter the dise se, o com shock, or heart failur : List only o	plications that cause to	he death. not e						14/014	Approximate Interval Between
	Physician/	ļ V	Immediate Cause (Final disease or condition		KA CEV						= 1	Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a	consequence of):	-		•				
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E R	sician: The law i certificate has t irector, page 2 s	Be Co	25. Was case referred to medical				26. Place o	f Death (Chec		ormed? 2 X No	1 🗌 Ye	s 2 X No
Vita	hysici his cer Il direc	욘	examiner? 1 ☐ Yes 2 X No		nt 2 ER/Outpat		Other:		ome 5 🗌 Resi	dence 6	Other (Spec	ify)
n of	ding P h. After t funera	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	Year) 28b. Time injury		3c. Injury at work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury o	occurred	
Division of Vital Records,	Attener deat ector.	Certificate;	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	/ - At home, farm,			2 🗆 110			Number or Ru	ral Route Number,
Div	ital or irs afte ral Din	al Ce		building, etc.						wn, State)		_
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2 Medical Exam	sician: To the best of m iner: On the basis of exa se Practioner: To the ba	mination and/or inv	estigation, in n	ny opinion, de	ath occurred a	t the time, date	and place, a	nd due to the	cause(s) and manner stated.
	To the within To the compl		29b. Signature and title of certifier	se Fractioner. To the bi	est of thy knowledge		License num		ce, and due to tr			h, Day, 2011
				/	h/		P22	162		M	N 20	2010
	01		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type				21721	600	w Kni	July OLD VAINT
	Stat		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	10100	an 1	MU	y w	יאעכט	-1 74	INMOI EDWINE
	Registra	ir	UNIVA LOUIT A	checken 10.	The way							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7.15 A M es 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BA HIRONC osedni Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 216-72-516 Months Days Hours Min. (Month, Day, Year) Director Usual Residence of Decedent 28a-f show 10b. County aţ 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits notified 1 Tes 2 No MARY PAND 10e. Street and Number ō 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a on other traumatic event, the Medical Examiner must be I Funeral 21237 Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 1 ☐ Yes 2 KNo Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number WIFC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Department of Important: If it any injury or o ₫ 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a, Part 1. Enter the di complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Between or respiratory arrest shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Dav be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Clieck only one) Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and tit 29c. License numbe 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) ho 32. Registrar's Signature 1. Date filed (Month, Day, Year) State JAN 27 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1eWICZ 1:49 pm January 24 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2 □ F 12,1946 Director 181-36-8299 64 April Pa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Borough of Wyomissing Pa Berks 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1233 19610 USA Garfield Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. יבי ביים לליטיבי. מקני של פופה 1 and 2 should be filed within 72 hours after נ nt of Health and Mental Hygiene. : If item 27 is markad ----1 X Yes If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates 966-19 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Balkiewicz Cieslukowski Adam Mary ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pa 19610 Balkiewicz/wife 1233 Garfield Ave. Wyomissing, Elaine Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CharlesEvansCrematoryJan.28,2011Reading,Pa e of F meral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTIMORE, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic disease or condition resulting in death) cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician I for use as the buri Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day 5 Other (specify) 2 No P.O. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, The law requires t 1 Tyes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 \ No 1 Tyes 2 🗌 No Yes this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Tes 2 No 1 YInpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar

HRVIND 31. Date filed (Month, Day, Year) JAN 27 2011

29b. Signature and title of certifier

PANDE \$2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

January 24, 2011

DHMH 17 Rev 1/2001

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 23 2011 **Physician** Natverlal B. Barot /Medical 4. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MMORE Date of Birth (Month, Day, Year) 5/28/29 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) **Funeral** Days Hours India 1 X M 2 □ F Director 215-06-6440 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

La cortant: If item 27 is marked other than "natural", or items 23a or 28a-f show in iury or other traumatic event, the World II Examing must be notified at 1 ☐ Yes 2X No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 83 Heatherhill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Indian Ş. 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laxmiben Barot Bhikhubhai Barot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7101 Milbury Court Elkridge, Maryland 21075 Bharat Barot Son 20b. Place of Disposition (Name of Bal-millanorecation) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) @ Loudon Park Baltimore, Maryland 1/26/11 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave. Baltimore, Maryland EZZ 23a, Part 1. Enter the disease, or computations that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovasular liseas ear S Physician /Medical Due to (or as a consequence of): Examiner pheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or a consequence of): Examine be executed Diabetes and burial-tran ue to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been situated funeral director, page 2 should a Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 DH0 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 3 DOA 1 Yes 1 Inpatient Certification: To 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

⊙ State

Registrar

900 Scation Ave, Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mason

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancie W. Clarke Janua 1:50A 2011 Medical 4a. Facility Name (A not institution, give street and number) 4b. City, Town, or Location of Deat **Examiner** unty of Deatl MOre 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Days Hours Min (Month, Days) ec. 29 .1928 Country) 290-26-1875 82 Ohio **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Catonsville 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 713 Maiden Choice Lane #2312 21228 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 Married P Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher/Administrator Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Wettrich Mary Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Richard Clarke / Husband 713 Maiden Choice Ln., #2312, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2011 | Baltimore, Maryland Metro Crematory Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Ph. sician/ 10 Vascu disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months2 Month 2 -116 g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed' 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Hospital 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4- Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital within 24 hours a Medical 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARROL Mor Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Reedbird Ave Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 🗆 M 2 🖳 F Director MD 02 07 212-28-3020 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21225 612 Reedbird Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic Worker 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Holmes Clifton Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 612 Reedbird Ave, Baltimore, Md 21215 Lessie Gannon-Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/29/2011 Laurel, Md National_ Park Signature of uneral Service License March F/H West 4300 Wabash A 21215 Baltimore, Md Wabash Ave, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line mins diate Cause (Final Tease or condition resulting in death) et and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician dbe detached for 11sp as the best of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Year Month Day Pregnant at time of death 2 🗌 No 1 L Yes 2 L 9 Dunknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been siy completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and on investigation, army spansor, and graded at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year)
JAN 2 7 20

DHMH 17 Rev 7/2009

State Registrar 37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23atate of Maryland Coperty 2011 (health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 01 15 Physician 2011 1:30 Ам Vesteria Louise Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 12/11/1958 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2X F 52 215-72-2657 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at 1 ☐ Yes 2X No Harford Perryman Maryland Funeral Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21130 USA 208 Specutia Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or iteme 11. Marital Status 1 Never Married 2 ☐ Married Specify Black 1 ☐ Yes 2 🛣 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Janitor 11 other 18. Mother's Name (First, Middle, Maiden Sumame) or other treumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 is marked ott Ethel Dorsey Raymond Cooper, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 208 Specutia Rd., Perryman, MD 21130 Ethel Cooper / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. 1/25/2011 Aberdeen 4 □ Donation 5 □ Other (Specify) Grove Cemetery 21. Signature Soneral Service La Tärring-Cargo Fluneral Home, P.A. 333 S. Parke St., Aberdeen, MD 21001 sone Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any, loading to infractionate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hypotension attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ESPIRATORY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an director, page 2 certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director; completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-17-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 Kevolutim 32. Registrar's Signature 31. Date filed (Menths State

Registrar

38,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24^{Day} Physician/ Jan. Pauline Daniel 2011 11:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care of Potomac Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1 M 2 XF Months Days Hours Min. Dec. 21 216-12-6403 90 Director Usual Residence of Decedent 28a-f shov 10a, State 10d. Inside City Limits 10c. City, Town or Location must be notified at Director Anne Arundel MD Edgewater 1 Tes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 115 Riverside Road United States 21037 within 72 hours after death with 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretarial Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment. Important: If item 27 is marked any injury or other traummone. William Poole Carrie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Riverside Rd., Edgewater, Maryland 21037 Edgar Snyder / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metro Crematory or other place)

Metro Crematory Inc

01/25/2011 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant Unknown Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 1 No ٩ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000545 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunithor Bhogailli 9801 (1010) AVNU 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 27 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 01/22/2011 **Physician** 0815A M Robert Young Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Caton Manor Center 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1940 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1X M 2□ F 70 NC 243-62-0750 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

A rant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1X Yes 2 □ No Funeral Director Baltimore City MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21217 USA 727 Druid Pk Lake Dr Apt 10J 13. Was Decedent of Hispanic Origin? (SpecIfy Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify. Specify: Black ģ 3 Widowed 4 NDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Food Service Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Uryles Spurill Virginia Davis 7 is marke ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cleo Rease 1438 North Milton Ave Baltimore MD 21213 20c. Location - City or Town, State 20a. Method of Disposition V NK 20b. Place of Disposition (Name of LAK cemetery, crematory or other place) Vn/7 Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A Weatherford FS PA 21. Signature of Funeral Service Licensee Philip Bu eather) Q 2431 E.Oliver St BaltimoreMD 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final da **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Physician: The law requires that the death certificate be executed Exami g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year ō 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes ZNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Affer t Hospital or Attending 5 ☐ Pending investigation 1 Alatural after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined i 24 hours after c e Funeral Direct filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0

State

Registrar
DHMH 17 Rev 1/2001

Hammond

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Honon

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 33 PM an Medical Mildred Dumphy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospita Kandallstown Balhmore Northwest Country 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** (Month, D. 8/28/ 1 M 2 AF Hours Min. Director 10b. County 10c. City, Town or Location 10a. State with the Maryland 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 28a-f 1 Yes 2 No Ellicott City MD Howard 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a USA 21042 3148 Bethany Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 P No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even ٥ Ernest Adam Wolf Margaret L. Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. Smith / Cousin 7925 Briarglen Drive Elkridge, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🏲 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2011 <u>Baltimore Crematory</u> Baltimore, Marvland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lioensee 3620 Wilkens Ave. Baltimore, maryland 21229 23a. Part 1. En or the disease, or of shock, or leart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause o n ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burlal-trans Due to (or as a consequence of resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending of the detached for use as IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed?/ Yes 2 No In ure integrated within 24 hours after death,

To the Funeral Director, After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No ျှ 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 1 Natural
2 Accident
3 Suicide 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one

29b. Signature and title of certifie

31. Date filed (Month, Dav. Year)

JAN 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

82. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Kandalletown,

29d. Date signed (Month, Day, Year)

MD 21133

11-00397	Please Type of Print in Black Indelible ink. Ens	ure All Copies Are Legible.	
Kathleen Laura Glancy	State of Maryland / Department of Health	and Mental Hygiene	0173
1- For State	Certificate of Death	4011	0110
Registrar	Certificate of Death	Reg. No.	
		0.01 (0.0)	T =

		1- For State Certificate of Death Registrar		g. No.	11/30
Physic		1. Decedent's Name (First, Middle,Last)	Date of Deat Month	h Day Year	3. Time of Death
Medical Exam	iner	Kathleen Laura Glancy 4a. Facility Name (if not institution, give street and number) 14b. City, Town, or Location of Division January 2	1, 2011 4c. County of Death	1815 hrs	
S. S. S. S. S. S. S. S. S. S. S. S. S. S		1 Montauk Court Parkville		Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		h(MM/DD/YYYY) 9. Birt	hplace (State or
Director		058-38-4393 1 M 2 X F 57 Yrs. Months Days Hours	May 3	, 1953	n District Intry Columbia
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .					1 Yes 2 No
Maryland 28a-f show	엻	Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	itry?
th the Maryland 23a or 28a-f sho notified at once	ä	1 Montauk Court 21234		USA	
hours after death with the Maryland natural", nr items 23a or 28a-f she Examiner must be notified at once	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Married 4 Married Forces? 13. Was Decedent of Hispanic Origin? 15 If Yes, specify Cuban, Mexican, Pur			can Indian, Black,
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	,	Specify: Wh	ite
urs afi itural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/I	
2 3 7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		
within within grene.	ᄩ	17. Father's Name (First, Middle, Last) 5+ Logistics Engineer 18. Mother's Name (First, Middle, Last)	ame (First, Middle, M	Chemical D	etection
21215-0036 21215-0036 ould be filed within 7 i Mental Hygiene. i marked other than ic event, the Medica			ldred K. I		
212 hould b nd Men is marl	10E	John E. Glancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Num	ber, City or Town, State,	Zip Code)
e, MD I and 2 sho Health and item 27 is		Thomas X. Glancy, Cousin 624 Wilton Road Tows 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	son, Mary	land 21286	
		1 Burial 2 Cremation 3 Removal from State crematory or other place)		20c. Location - City or	
Baltimo permit Pages Department o Important:		4 Donation 5 Other Specify: Metro Crematory Inc. 02 1. Signature of Funeral Service Gensee Thomas Gregor Cremation Society 2. Name and Address of Facility Cremation Society	L/24/11	Baltimore	, Maryland
Department of the partment of		21. Signature of Funeral Service Censee Thomas Gregor 22. Name and Address of Facility Cremation Society 299 Frederick Roz 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	/ Of Maryl	land, Inc.	od 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause or each line.	ac or respiratory arre	st, shock, or heart	Approximate Interval 8etween Onset and
`/Medical ≿xaminer		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Di	sease		Death
همديد. ه		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
. 4.	Examiner	C. Due to (or as a consequence of):			
760, cate be executed the burial - transit		d.			
'60, rate be exc physician	Medical	x unpended 23a,27 per me g913 3-2-11 v	t		
876 tificate ng phy as the {		IF FEMALE: 23b. Was decedent pregnant in the 2ctopic pre sent 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending p	Physician/	Pregnant at time of death 5 Other (Specify)			
b. Be the de cy the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute to t	he cause of death?
P.O. es that the igned by be detacl	d by		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed		24a. Was a		opsy findings available
Reco	omp		perform 1 ✓ Yes 2	ned? death?	
zal Ritan: 1 tan: 1 certific ector, p	Be C	25. Was case referred to medical examiner?	ck only one)		
f Vid Physic er this	To	1 ✓ Yes 2 No Indignation 2 ER/Outpatient 3 DOA Outer 1 Nu		Residence 6 Other:	Scene
nding nding th. r: After e fune	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No	Zod. Describe no	ow injury occurred	
risic r Atte ter dea rirector	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Rur	al Route Number, City
Div pital o ours af eral D	Certi	4 Homicide determined (Specify)	or Town, Sta	ate)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the		29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a well one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred the course of the course o			
Tot Tot comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	st and time, date a	29d. Date signed (Mon	
2.1		(M) O.C.M.E.		January 22, 2011	,,,
CKROO		30. Name and address of person who completed cause of death (Item 23a)			
Oct		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Bal	timore, MD 212	23	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signiture			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Physician/ GOR (Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Randallstown Baltimore Season's Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** 1 M 2 X Months Hours Min. Director Yrs 220-24-6240 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21216 2317 Braddish Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed 3 XWidowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than feet injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Adm Data Processor 12th grade 2vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Miller Oueen Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Vanessa Griffin-Granddaughter <u>6712</u> Alter Street, Baltimore, Md 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 2/3/2011 Arbutus, Md of Funeral Service Lices March F/H West 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause of a lack line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗌 No 1 ∐ Yes 2 L 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2**/2** No Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. Natural 2 Accident injury work 5 Pending 2 No Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: within 2 To the I only one 29b. Signature and titl e and address of person who completed cause of death (Item 23a) (Type, Print 100 6 31. Date filed (Month, Day, Year, 32. Registrar's Signature JAN 2 7 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jannth. Florence Hoffman 25^y 201°1 6:00 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City 5518 North Charles Street N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 💢 F Hours July 31, 1917 135-03-0031 New Jersey **Director** 93 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director N/AMD Baltimore City 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 5518 North Charles Street 21210 United States I Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Manufacturing Elementary/Seconday (0-12) College (1-4 or 5+) Company Book Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Leo Rohrbach Sarah Kaul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Charles Hoffman / Son 5518 N. Charles St., Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 101/26/2011 |Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Hend Failue Onset and Death Physician/ maestie disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

3 Other (specify) ____ nse 23b. Was decedent pregnant 23d. Date of delivery for L in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ evantants 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Oslevporosis 24a, Was an cate has page 2 s autopsy performed? Yes 2 No Itypothymalism or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending s after death.
I Director: Aft
id in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direct completed filled in b. Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) y & mo D37133

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

76,00 Oslen Prine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

MD

32. Registrar's Signature

Robert June.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State State Registrar	•	partment of Health al Certificate of Death	, ,	giene Reg. No. 0	01739
Н	Physicia	an	1. Decedent's Name (First, Middle, Last)	14		2. Date of Dea Month	Day 26 Year	3. Time of Death 10:05 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of	Death	4c. County of Deat	10.000
			Charlestown Care Cent	er	Catonsv		Baltimon	
П	Funeral		5. Social Security Number 6. Sex 1 M M 2 □	7. Age (In yrs. last birthd	Months Days Hours	Min. (Month, Day	y, Year) 9. Birt	thplace (State or Foreign ountry)
١.	Director		Usual Residence of Decedent	90 118		Sept. 2	,1920	Indiana
	yland		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
:	e Mar Sa∽fsl	ctor	MD Baltimore		Catonsvil	le ·		1 □Yes 🌉 No
:	be flied within 72 hours after death with the Maryland thylgiene. do other than "natural", or items 23a or 28a-f show event, the healtest Exeminer must be notified at	Funeral Director	10e. Street and Number	"	10f. Zip Code		10g. Citizen of What Co	-
:	sath w	eral	719 Maiden Choice Lane		21228	ing (Consider Value and Na	United Sta	
•	ter de	Fun	Armer	es 2 No 1942-	 Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 	Puerto Rican, etc.)	14. Race - Ame Black, White	
9500-	urs a al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Year of	Give 1945	1 ☐ Yes 2 🔀 No Specify:		Specify: W	nite
ှ ဂ	72 ho natur dical	Completed	15. Decedent's Education (Specify only highest grade complete	16a. De	ecedent's Usual Occupation live kind of work done during most of ie. DO NOT use retired)	of workina ı	16b. Kind of Business/	Industry
7	within 72 iene. than "nai he Medic	dm			ie. DO NOT use retired) Ongress Aide	I	Government	
7 - 0 -	e filed v al Hygie l other l vent, in		17. Father's Name (First, Middle, Last)	00 0		s Name (First, Middle,		
a	should be nd Mental marked o matic eve	To Be	John Junk		Ellen	•	,	
מכ	2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street and Number		r, City or Town, State,	Zip Code)
2	and 2 ealth a n 27 is ner tra		Kenneth Junk / Nephew		2 Londonderry Ln	., Ft. Wayı		
<u>ب</u> س	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from		sposition (Name of crematory or other place)	Date	20c. Location - City or	
	trmen tant: tant:		4 ☐ Donation 5 ☐ Other (Specify)	Metro C	rematory Inc 0	1/27/2011 1	Baltimore,	Maryland
20	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service Licensee Ally	son K Taylor	22. Name and Address of Facility 299 Frederick R	Cremation S d., Baltimo	Society of ore. Marvla	Maryland and 21228
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not				Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition		out failure.			Onset and Death
	/Medical xaminer		resulting in death)	ty or as a consequence of):	7			
		r.	Sequentially list conditions, b.	to (or as a conso) tence of (
6	ured d ansit	Examiner	Sequentially list conditions, any leading the first description cause. Enter Underlying Cause (Disease or injury that initiated events c.					
٠ 1	an and	ш	resulting in death) Last C. Due	to (or as a consequence of):				
00/00, d,	inicate be executed by physician and as the burial-transit	edical	d		· · · · · · · · · · · · · · · · · · ·			
Ď	ding p		IF FEMALE:	outcome of prospensy				
מַב בּ	atten for us	cian,	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death regnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
; §	y the	hysician/N		nknown	5 🗆 Other (specify)			
r the	ned be deta	by P	Part II. Other significant conditions contributing to	/ .	e underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
colds,	en sig	edb	Chronic Kidney	Ashe.		1 🗆 Y	es 2☑No 3□P	robably 4 Unknown
ב ב	as be	ompleted	Hypertension			24a. Was a	an 24b. Were au	utopsy findings available completion of cause of
ב ב	cate h	CO .	//			perfor 1 □ Yes	med% death?	2 □No
VILC	certifi ector,	Be	25. Was case referred to medical examiner? Hospital:		Other	of Death (Check only or		
5	rthis ral dir	5	1 163 2 1 100	☐ Inpatient 2 ☐ ER/Outpa ate of Injury 28b. Tim	tient 3 DOA 4 Nurs		ence 6 Other (Spe	ecify)
5 5	th. :: Afte	tion		fonth, Day, Year) Inju			on injury documen	
2 5	ector by the	Certification: To		ace of Injury - At home, farm, illding, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Ri	ural Route Number,
5 3	rs after or ral Dir	Cer						
H	to the nospino of strending rivs trait in the law requires that the beart between the trait the beart between the Law A hours after death. To the Expensal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	Medical	(Check only 2 Medical Examiner: On the		eath occurred at the time, date and or investigation, in my opinion, death			
Ę	withir To th comp	Me	29b. Signature and title of certifier	A	29c. License number	2	29d. Date signed (Mont	th, Day, Year)
	H		14 10	to ru		297	1/26/	/11
	8×1		30. Name and address of person who completed of Michael K. Res	ause of death (Item 23a) (Tyl	1	Catenso	ille Mo	21228
	Stat Registra		31. Date filed (Month, Day, Year) 32	2. Registrar's Signature	,			
	riegisti		JAN 27 2011 Servera	1 p. garke				

11-00589 Diane Kinslow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iane Kinslow	Registrar	tezat Maryland,/ge	Certificate	of Death			\(\lambda \) \(01/40
Physician/ Medical Examine	Decedent's Name (First, Middle		arie 1	Kinslow		Date of Death Month D anuary 21,	ay Year	3. Time of Death 1508 hrs
TEUICAI EXAMINATE	4a. Facility Name (if not institution			4b. City, Town, or Loc		anuary 21,	4c. County of Dea	ath
· ·	Good Samaritan Hospi			Baltimore				2:46-1
Funeral Director	162-70-5455	7. Age (In 1 M 2 X F	n yrs. last birthday)		f Under 24Hrs. 8 Hours Min.	•		eign Country) PA
any	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits
A	MD	na	Baltimo	ore				1 X Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number	<u>'</u>		10f. Zip Code		10g.	Citizen of What Co	ountry?
th the 23a or notific		rne Avenue	or in II G	21 Vas Decedent of Hispar	214	fy Yes or No-	USA 14 Race - Am	erican Indian, Black,
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	11. Marital Status 1 Never Married 2 X Mar		If	Yes, specify Cuban, M			White, etc.	
s after de real", or niner m	3 Vidowed 4 Divo	ced If Yes, Give Year or Dates:	1_	Yes 2X No s			Specify:	ite
hours fratur Exami	15. Decedent's Education (Speci Elementary/Secondary (0-12)	y only highest grade comple College (1-4 or 5+)		ent's Usual Occupation most of working life. DO			6b. Kind of Busines	s/Industry
5-0036 ed within 72 hour hygiene. to ther than "natu the Medical Exan Completed	- Liementary/occordary (o 12)	5+	At	torney			Legal A	id
		•		1	Mother's Name (Fi			
2121; ould be fill d Mental Is s marked fic event,			19b. Maili	ng Address (Street ar	Dorothy nd Number or Rura	A. Da I Route Numbe	A.V er, City or Town, Sta	ate, Zip Code)
MD 2 should be sailth and 1 straumatic	Dennis V. Ki	nslow-Fath		2 Hallman			n, PA 1	
Baltimore, ME permit. Pages I and 2 s Separament of Health a Stanportant: If item 27 injury or other traum.	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	crematory or		,		20c. Location - City	
Baltimore, permit. Pages la Repartment of He Emportant: If ite	4 Donation 5 Other Spe	cify:		le Cemete	ry 1-29	-2011	Roslyn,	PA
Balt Permit. Peparti Import injury	21. Signature of Funeral Service L		1.11	.101 E. No			ast F/H Balto,	MD 21202
Physician	23a. Part I. Enter the disease, or of failure. List only one cause of	omplications that caused the	death. Do not enter	the mode of dying, suc	ch as cardiac or re	spiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Throm						Death
	Sequentially list conditions,	Due to (or as a consequent).	ence or):					
iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	ence of):					
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last							
50, te be executed sysician and burial - transit	UNPENDED	dAMENDED						
'60, ate be physician Medi	IF FEMALE:	23c. If yes, outcome of	of pregnancy			-	23d. Date of deliv	•
b. Box 68760, the death certificate be by the attending physicicle for use as the burn Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tim		Fetal death 3 Other (Specify)	Ectopic pregnancy	′	Month	Day Year
Box e death the atte ed for u	1 Yes 2 No 9 ✔ Unkr	3 GINGIOWII						
ires that the signed by I be detach			ut not resulting in the	e underlying cause give	n in Part I.		2 ✓ No 3 P	to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachrification: To Be Completed by F	reroe injuries, remains					24a. Was an autopsy		autopsy findings available o completion of cause of
ecor he law i te has b					-	performe		?
Vital Rec ysician: The his certificate director, page					Death (Check only			
f Vit	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	11 0 D3/1	Nursing H	d. Describe hov	esidence 6 Oth	
on of anding Plan. After he funera	1 Natural 5 Pendi	ng Jan 12, 2011	0840 hrs		. ₂√ No Sι	bject driver		ed in collision with
Division of Valuation 🗹 Accident Invest 3 Suicide 6 Could	not be	/ - At home, farm, st	reet, factory, office build			eet and Number or te) t Manor Rd., Gler	Rural Route Number, City	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	(Check only one) 2 Medical Exam	ysician: To the best of my kinner: On the basis of examin and manner stated.	nowledge, death occurrence and/or investig	gation, in my opinion, de	eath occurred at th	e time, date an	d place, and due to	the cause(s)
F. William	29b. Signature and title of certifier	and manner stated.		29c. License n			29d. Date signed (A	
	Molin K	rand 4, 11#	<u> </u>	O.C.M.	E		January 22, 20	T1
in	30. Name and address of person Melissa Brassell, MD	vho completed cause of deat Assistant Medical E		W. Baltimore Stre	et, Baltimore,	MD 21223		
State	2	32 Registrar's		Kel				

		•	•				-	Are Legible.		
		1 _ State	State of Ivia	ryland / Dep	rtificate of		, ,	7111	01741	
		Registrar 1. Decedent's Name (First, Middle, Last)			runcate, or i	Dealli	2. Date of Dea	th	3. Time of Death	
Physicia		Lula	Del1		Lan	e	Month O1	Day Year 2011		
/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of Death	01	4c. County of Dea		
Examin	C!	Manor Care Nursi		•	Caton	sville		Baltim	ore	
Funeral		Social Security Number 6. Sex		(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bir	thplace (State or Foreign ountry)	
Director		231-28-5107	VI ZAJIF	85 Yrs.			06 30	25	NC	
land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
Mary F sh	ţō	MD NA		Baltin	nore				1 XYes 2 □ No	
h the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	ountry?	
th wit		3737 Clarks Lane	Unit 4	10	21	.215		U.S.A	•	
tems	Funeral	THE THE STATE OF T	. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
72 hours after death with the Maryland raturals, or items 23a or 28a-f show deat Extrabolated 21	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	1 ∐Yes 2 XN If Yes, Give Year or Dates:	0	1 □Yes 2√No	Specify:		Specify:	Black	
72 hours "natural";	led			16a. Dece	edent's Usual Occup	pation		16b. Kind of Business	/Industry	
hin 72 e. an "na	ple	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+	life	e kind of work done DO NOT use retired	during most of work d)	ing]	Baltimore	City	
ed with	Completed	llth grade	na	Вос	ok Keepe			Municipal	Dept.	
be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)		
ould Men Tarke	ပ	Isaac Sessoms		T		Thelma			7: 0: (-)	
d 2 st th an 7 is r traur		19a. Informant's Name/Relationship (Type	Daugh	ter 373				r, City or Town, State,		
tem 2	}	Gwendolyn M. Dea 20a. Method of Disposition	nes		/ Clarks osition (Name of matory or other place		Date Bate	20c. Location - City or	Md 21215 Town, State	
ages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Wood	_		/2011	Woodlawn	, Md	
mit. F partm sortar / Inju		21. Signature Funeral Service Licensee		M ²	2. Name and Addre	1 *	·			
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" any injury or other traumatic event, It a Modical Expense.		> xonala C.	many	4.	300 Waba	sh Ave,	Balti	more, Md	21215	
		23a. Part 1. Enter the disease, or complication of the complete shock, or heart failure. List only one	ations that caused cause on each line	the death. Do not er	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
Physician		immediate Cause (Final disease or condition	AZZ		ER'S	DEME	NTIA		Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	-	Sequentially list conditions, b.	Due to (or as a	consequence of):	-					
uted J insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	540 10 (0. 40 0							
te be executed ysician and le burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):						
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leath certificate aftending physi	ian/	23b. Was decedent pregnant in the past 12 months?	i. If yes, outcome of 1 Live birth	2 Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	elivery Day Year	
The law requires that the death certifica ate has been signed by the aftending phage 2 should be detached for use as the	Physician/Medi	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify) _					
w requires that the diben signed by the should be detached		Part II. Other significant conditions contr	ibuting to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute to the cause of death?		
quires n sigr ald be	d by	HYPERTENSIVE C	ARDIOV	ASCULAR	- Dis	EASE	1 □ Y	es 2□No 3□F	robably 4 Unknown	
aw rec	Completed						24a. Was a		utopsy findings available	
The law cate has page 2 s	mo						autop perfor 1 🗆 Yes	med? death?	completion of cause of s 2 No	
ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
hysic this o	၉	1 ☐ Yes 2 No		nt 2 ER/Outpatie		4 ANursing H		dence 6 Other (Sp	ecify)	
Jing F	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		Wor	ryat rk?]Yes 2 □ No	28d. Describe h	now injury occurred		
death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Iniu	ry - At home, farm, s		ires ZLINO	28f. Location (S	Street and Number or F	Rural Route Number.	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, t	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,		City or Ton	in, State)		
ospita hours unera ly fille								cause(s) and manner a		
the Ho in 24 the Fu	Medical	one)	and manner sta							
Vith Vith Corr	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor		
		mp mp				159101		1-25-	11	
5		30. Name and address of person who com	210 Rand	ath (Item 23a) (Type	Print)	IVE . RS	18552	STOWN, M	D 21136	
Sta	tę	31. Date filed (Month, Day, Year)	/ 32. Registra	r's Signature	A I G \ P	140 / 10	17100			
Registr		JAN 27 2011 A	December !	r's Signature						
				5						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Oldio of Mic	aryland / L		ficate of i		110 1110	, ,	leg. No.		
	Physicia	an	1. Decedent's Name (First, Middle,	ŕ						2. Date of Dea Month	th 25 ^{Day}	2 U Year	3. Time of Death
	/Medic	al	Louis Mand 4a. Facility Name (If not institution,				lb. City, Town, or	. Location of		Jan.		2011 County of Death	2:30 A M
	Examin	ier	102 Shady Nook	1	Catons		Death		40.	Balti			
	Funeral Director				e (In yrs. last birt 96		If Under 1 Year Months Days		Min	B. Date of Birth (Month, Day Sep. 27	Year)	9. Birth	nplace (State or Foreign untry) New York
aryland	f show	or	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c. City, Town	or Local	tion Catons	ville					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N Sa or 28a~ I be notifi	Funeral Director	10e. Street and Number 102 Shady Nook				10f. Zip Code	21228		1	_	izen of What Cou ited Sta	untry?
3-003e	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Italia dical Evantian in the natified at once.	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?			as Decedent of Hes, specify Cuba		n? (Speci Puerto Ri	ify Yes or No- can, etc.)		14. Race - Amer Black, White	ican Indian,
0-6171	within 72 ho ene. than "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5	+)	(Give kir. life. DO	nt's Usual Occup nd of work done of NOT use retired l Worker	during most o f)	of working			nd of Business/I	•
ומוומי	uld be filled fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, L Jacob Mandel	ast)		<i>50 ca</i> .	I WOLKEL		s Name (First, Middle,			
-	and 2 shot ealth and I n 27 is ma her trauma		19a. Informant's Name/Relationshi Frances L. Bower									r Town, State, Z , MD 212	
	Pages 1 Iment of H tant; If iter fury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.			on Fo	ion (Name of fory or other plac orest VA	A 01		/2011	Owi	9	ls, Maryland
Da	permit. Departr Importa any Inju		21. Signature of Funeral Service L	icenseeAlyson K	Taylor							al Home, e, MD 21	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each ling	the death. Do note. S1V a consequence of	CA							Approximate Interval Between Onset and Death
	7.7	Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o								
00/00	rrifficate being physicial as the buri	Medical		d				-					
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Other Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		ctopic pregnanc other (specify) _	у				23d. Date of deli Month	very Day Year
COIOS, T	equires that sen signed b ould be deta	þ	Part II. Other significant conditions contribute to the cause										
מו חפר	n: The faw r	Completed	OF Wassers	70						24a. Was a autops perfor 1 ☐ Yes	sy med?	prior to c death?	topsy findings available ompletion of cause of
5 :	ysicia s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	int 2 🗆 ER/Out	tnationt	3 DOA Oth	or:		Check only or		6 □Other (Spec	
	ending Pn ath. vr: After thi ne funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Datation	ry 28b. T	ime of njury	28c. Injur Work		28	d. Describe h			ury)
בואות בי	ital or Attairs after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place of inju- building, etc	c. (Specify)					City or Tow	n, State)	ral Route Number,
	the Hosp nin 24 hou the Fune npletely fi	ledical	one)	Physician: To the best of xaminer: On the basis of and manner sta	l examination and	, death o d/or inve	stigation, in my o	me, date and pinion, death	place, ar occurred	nd due to the o	date and) and manner as I place, and due	stated. to the cause(s)
i	7 with	Σ	29b. Signature and title of certifier	A 5			29c. Licens		2			te signed (Month	, Day, Year)
	الماير		30. Name and address of person w	√ · D	eath (Item 22a) (Type D-		5910	†		01-	26-11	
	5,,		KAZU UMA	210 Bush	VESS C		,	z Re	1548	ERSTON	IN.	, mo.	21136
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:05 Goldie V. Rickle Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death AGNES HOSPITAL TMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) est <u>Virginia</u> 1 🗆 M 2 🔀 🕇 Director 218-28-8661 76 West Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1
Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2007 Harmon Avenue 21230 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sweetheart Cup <u>Factory Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Dawson Pearl May Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Harmon Ave. Baltimore, Maryland Robert E. Rickle / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 1/24/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Onset and Death Immediate Cause (Final dionathic Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Esophageal vasices, Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 2 No 1 ☐ Yes 2 🔼 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 061829 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

60100

- Clacer I MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician /Medical Silver Month 18:14 trtis 20 2011 Vanuar V 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11–6–1954 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days Hours Min 56 MD **Director** 216-62-2656 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 □ No **Funeral Director** MD na Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1401 Mountmor Court death \ USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 Xo Black Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry event, the Medical 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Various Jobs Maintenance llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fill lealth and Mental H ည Herman Silver, Jr Ester Mae Winstead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other traumones. Robert S. Silver, 1811 N. Warwick Avenue Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 **Burial 2 Cremation 3 Removal from State 1-28-2011 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** patitis disease or condition resulting in death) /Medical De to (or as a consequence of) Examiner deficiency syndrome acquired Imm ube Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical death certificate be as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy be detached for Month Dav Year 4 Pregnant at time of death 5 Other (specify) 2 No P.O. the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed: 2 No 2 🗹 No 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 2 No 1 Tes 1 Inpatient 3 🗆 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) ည this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 5 Pending investigation 1 Natural Injury 2 🗌 No 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-1000 2011 January 20

State Registrar Sophie

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wells

JAN 27 201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 0630 A alph Qumpter /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Genesis Hamilton Balto If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days 1**X** M 2□ F Months Hours Yrs Director 214-58-8109 59 6-17-1951 Texas Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hyglene. Important: If them 27 is marked other than "naturel; or items 23s or 28s-f show 10a. Stete 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f ahow treumatic event, the Medical Examinar must be notified at MD X□ Yes 2□ No Baltimore Director na 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1509 N. Wolfe Street 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Janitorial Service College (1-4or 5+) 10th grade Janitor 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Eris Howard Sumpter Lou Heln Floyd 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Niece Tanya V. Pindell-Judd 1315 Roxboro Road Rosedale 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/25/11Parkville, 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Balto, MD 21202 Avenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Coronary artery desease, Due to (or as a consequence of): Examiner Examiner mitral value attending physicien end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown signed by 1 ☐ Yes 2 ☐ No Mitral Value 2 been signe should be 24b. Were autopsy findings available prior to completion of cause of deeth? Completed patic Cirrhosis 24a. Wes an eutopsy cate has t ereprovascular disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Visorder Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 the Funeral Director: After this operated in by the funeral 28c. Injury et Work? 27. Manner of Deet 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1/Naturel deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours of Funeral edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name end address of person who pempleted cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

JAN 2

ORIGINAL

Isma

32, Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygierie ()

Certificate of Death

Reg. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 01/22/2011 **Physician** 0236A M Roger Lee Oliver Scott Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City 2432 Wilgray Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1

▼ M 2□ F 55 Yrs. VA Director 7/27/1955 218-74-6742 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maries Extrainer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ¥ Yes 2 □ No Director MD Baltimore City 10e. Street and Number Wilgrey 10f. Zip Code 10g. Citizen of What Country? USA 21230 Wilgray Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □ No 3altimore, Maryland 21215-0036 Specify. Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerldine James Scott ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter 2432 Wilgray Ct. Balto MD 21230 Scott Ivory 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ts Registry /23///
22. Name and Address of Facility PHillip A. Hanover MD Gifts Registry Ant Weatherford FS PA 21. Signature of Funeral Service Licensee 2431 E. Oliver St Baltimore MD 21213 TAIL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Physician HEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760, pe Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the temperal presents. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes 2 🔲 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 XNo 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2XNo 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier R162370 Greene St, S9CIG, Baltimore, IND. 21201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year STINFBAUGH AM Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MARGLANA 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗷 F Min. (Month, Day, Year) 3/28/35 Director 213-32-9160 Maryland Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Thipportant: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Medical Examiner must be notified at Order. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21223 326 S. Monroe Street USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stella L. Minnick John Howard Foertsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Foertsch / Brother Baltimore, Maryland Monroe Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 1/28/2011 Baltimore, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRYIST disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauc. Enter Indentity Examine Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 🗹 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner's Hospital: 2 1 No 1 🗆 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manyier of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1/21/201 19.0 50069015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN Edwards 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2250 Cornelius 201 rent Janvari Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkin Bayyim Midical Centr Battimox If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 2-5-1938 1 X M 2 □ Months Country) 213-32-4000 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than any injury or other than 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD Baltimore na 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21213 USA 2862 Pelham Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes XXNo 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housing Authority Maintenance Worker 6th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Cornelius Trent, Sr Knowland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2862 Pelham Avenue Balto, MD Josephine Trent-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Pk 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD 1-31-2011 Randallstown, 22. Name and Address of Facility 21. Signature of F eral Service Licensee March East F/H alist. Ε. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Physician/ Acute renal failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ung cancer Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown as been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Director: After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA ျ 1 Yes completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital within 24 hours a To the Funeral E

DHMH 17 Rev 7/2009

State Registrar (Check

31. Date filed (Me

29b. Signature and title of certife

Anna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mp

4940

Registrar's Signatur

Eathern Arner

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1401-000

Bathma Mr 71724

29d. Date signed (Month, Day, Year)

Januar 22 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 7:08 PM Zakroski Edward John 2011 П 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death agminer sbur CO vasta If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday Days **1**X ■ M 2 □ F Min November 29. Yea 1938 72 MaryTand 215-34-7814 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Worcester Berlin MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21811 60 Anchor Way Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Vietnam Year or Dates. any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smutek Edward Zakroski Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 Sarasota Ct., Ellicott City, MD 21042 Donna L. Horn (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Loudon Park Cemetery Baltimore, Maryland 1/29/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lieusee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Parl + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes /2 After this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hustin 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Ohn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23aPtI,25 per me 3911.01/28/2011dhb Reg. No. For State Registrar 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Yea 19:21 PM **Physician** KATHERINE 2011 ENMARY 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner UEDICAL CENTER BALTIMORE N/A BETVIEW HOPKINS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🗗 F 78 5,1932 235-54-7343 West Director Sept. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County al Hygiene, other then "naturel", or Itema 23s or 28s-f show vent, the Medical Examinat must be notitled at MD 1 ☐ Yes 2 No Dunda1k Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 7900 Diehlwood Road United States Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Co. Inspector 12 Years traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth eny lipury or other traumatic event 9DEs. Be Fern Parrish 2 John DeMarco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7900 Diehlwood Road Mr. Robert L. Allen(Husband) Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Shinnston Masonic Cem. 1/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Shinnston, WV 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature di Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear called the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in tracevebral Hemorthag? 20 hrs **Physician** /Medical Due to (or as a consequence of): NONI Probable complications of Hypertension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical signed by the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Ö 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 105 2 ⊠ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director; After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 🗷 Natural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and of certifie 29c. License number 29d. Date signed (Month, Day, Year, ANUAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 "oland aston MI Romanus à 32/Registrar's Signature 31. Date filed (Month, Day, **2**8 20 State

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Registrar

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year APPLESTEIN 0935AM KAREN 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death NORTHWEST RANDAUSTOWN HOSPITAL BALTIMOR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Pay, Year) 1942 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Mary Land Director 220 36 -1 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1 Brett Court Apt.330 21221 USA items ? within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Robert Hinton Holbrook permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Bertha Pitcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morton Applestein (Husband) 1 Brett Ct. Apt. 330 Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Inc. 1/26/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 W. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ SEPSIS ONDARY TO PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner OSSIBLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events ANEMIA or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, KID NEY Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital 1 ☐ Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 5 \square Pending iniury 2 🗌 No Investigation Could not be hours after dear neral Director: 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Funeral Medical 1/X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practifier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 2. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI RUPINDE R JEET SINGH SANDHO

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 2 5 2011

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 853 AM Month Physician/ Ernestine Delores Addison Tar Medical 4c. County of Death Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days April Ty 1 □ M 2 🖾 F ^{rear)}935 North Carolina Yrs. 217-34-4335 75 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland N/A Baltimore City 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21218 1508 Lakeside Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black White, etc. δ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give ¾ Widowed 4 □ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dept. of Social Service Casework vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Mattie Kirkman Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Tolson/Daughter 1526 Pentwood Road Baltimore, MD 21239 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/01/2011 1 Burial 2 Cremation 3 Removal from State Owings Mills,MD Cem. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 ann 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner alla orman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death certificate has been signed by the a irector, page 2 should be detached f 9 | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 Yes 2 Ho 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this and annieted filled in by the funeral di 27. Manne f Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 \sum Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-23-2011 D52016 almare Wajel Samara, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23/2011 21218 MD Na 4 640 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 12:15 PM Marlisa Juanita Arrington 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Union Memorial Hospital . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country Mary land 1 🗆 M 2 🗹 August 5, 1965 45 **Director** 219-78-5242 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 1728 E. 32nd Street 21218 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Specify: 'natural", Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed N/A 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic v Gail Anita Ausby John Louis Arrington, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2924 W. Coldspring Lane Apt. B Baltimore, MD. Juanita Wilson - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 1/31/2011 Woodlawn, Maryland 21. Signature of Face ral Service Libert 22. Name and Address of Facility Chatmen-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Jascu erebra disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** potension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Stage Rena Disease Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Diabetes Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnanτ : 9 ☐ Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ည 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injurv 1 M Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0066212 23,2011 January dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name ark Parkway, Baltimore, Maryland 21218 Amy McClosky East University JAN 2 8 201 State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ 201 _M **AUERHAN** ANITA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE COURTLAND GARDENS Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 🛛 F 0574871930 MD 80 Director 214-24-4905 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1X Yes 2 No BALTIMORE N/A MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 21215 USA 2500 W. BELVEDERE AVENUE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. HOMEMAKER OWN HOME 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ t. Page 1 and 2 should be to treent of Health and Ments tant: If item 27 is marked jury or other traumatic e WARSHOFSKY SHERMAN FANNIE HYMAN t and Number or Rural Route Number Heights Ave 1:44 CT 19a. Informant's Name/Relationship (Type, Print) Gity or Town, State, Zip Code Baltimore, MD 21 RAITIMORE, MD 2 19b. Mailing Address (Street Park EDWARD AUERHAN/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 101/27/2011 BALTIMORE, MD WORKMEN CIRCLE CEM. 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death ØL Physician/ Me. disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Mu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ев е соввесинись об attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2: certificate has performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The 2 2 25. Was case referred to dical 26. Place of Deat heck only one) **Division of Vital** Be director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be ☐ Accider☐ Suicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier mu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Betweelene are felh more pen 2/2/5 22. Registrar's Signature 31. Date filed (Month, Day, Year) State 28 2011 Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death Physician/ Month 155 PM anuary Medical 4a. Facility Name (if not institution, give street and number)

Loch Raven VA Community Living & Rehab 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Nov. 26,1922 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 145-18-3095 88 **Director** Irvington. N.T Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland by Funeral Director the Medical Examiner must be notified MD Baltimore Towson 23a or 28a-f 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 United States permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Hospital Registered Nurse 5+ other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ္ Raymond L. Aumack Lorentine A. Sander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 606 Baltimore Avenue Ste. 100, Towson, MD 21204 Frederick Raab/ Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Januatry HoTItywood Memorial Park Cemetery 1 X Burial 2 Cremation 3 Removal from State Union, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 29, 2011 21. Signature of Funeral Service Licensee TValls Funeral Chapel & Cremation Services 8000 Harford Rd. Parkville, MD 21234 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Open and Death Metastatic Breast Impediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to jor as a consequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? as been signed by the atte 2 should be detached for Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available autonsy prior to completion page death? 1 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: ပ 1 Tys HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No safter death.

Director: Aff 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) NSI Day, Year) N 2 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year シムルムヨビ BURKE JANUARY 5:82 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL BURNIE GLE N 8. Date of Birth (Month, Day, You 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 1 M 2 MF 194-14-3460 Months Hours Director HENUSY4WANIA Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No ANNE ARUNDE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21061 403 W. ORDINANCE RD. ural", or items ? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ρ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ₩idowed 4 ☐ Divorced "natural" Completed MITE Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RAYMOND TRUXAL STELLA MARY COPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1921 MANISION HOUSE CROSSING. PASADETAL MD. 21122 RKE injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ARUNDE CREMATORY 4 Donation 5 Other (Specify) ODENTON, MO. peral Service Livensee 22. Name and Address of Facility DaughERTY Functor Home ZLOCK MOUNTAINIRD. Part 1. Enter the disease, as complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ PRUCHI PSHOWS STUDA 2 Mys disease or condition Medical resulting in death) Examiner 2 DAYS DUIDSELA LAUINODAL ARTUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 2 140 1 Nation 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury s after death. 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ► Cosis Construction Contractor MD 11753000 1105 cP 494U4AC

m

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signature

GUILLERMO DOSE GIANGRECO BOI HOSPITAL DRIVE, GLEN BURNIE, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward Banks 01/20/201 6:16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Min 05/09/ Philadelphia Director 174-40-1684 61 Usual Residence of Decedent fshov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X☐ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2413 Montebello Terrace 21214 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian vvas Decedent Ever Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black 1 Tes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Dept of Rec. <u>Baltimore City</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward B. Banks Helen Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Banks (brother) 5739 Woodbine Ave., <u>Philadelphia</u>, PA19131 permit. Page 1 and Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place IOSEPH BROWN F Nd Crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/24/11 Baltimore, MD 21. Signature of Funeral Service Licensee 2148 enh Hulben Aver.; Kun Euneral Homed PA1217 234. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoek, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Cardiac Arrhythmia minutes Medical Due to (or as a consequence of) Examiner Hyperkalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated second hours Due to (or as a consequence of) Exami burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 X Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🔀 No မှု 1 Yes 1 DCInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 2 🗌 No 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) D43003 January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nathan A. Dunsmore M.D **GBMC** Towson, MD 21204 6701 N. Charles St. 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

JAN 28 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 209 FM Januar Medical 4a. Facility Name (if not institution. give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death nne Colical 9. Birthplace (State or Foreign Country) Mississippi 8. Date of Birth Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D F Months Hours Min Vrs **Director** 60 290-46-3722 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 1 ☐ Yes 2 X No Anne Arundel Severn MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21144 7933 Bent Bough Road United States 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 No Black, White, etc. 1 Never Married 2 X Married by altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Specify: Completed Black Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Computer Technician United States Army other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ James L. Branson Lennie B. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Enelda Branson / Wife 7933 Bent Bough Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 01-31-2011 Crownsville, Maryland 21. Signature of uneral Service 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Nyacardia Physician/ Arction disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or se a consequence of, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death g Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Director: After this certificate 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes Other: 2 🗆 No ၉ 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 \square No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Completed filled edical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Deputy 29b. Signat 29d. Date signed (Month, Day, Year) and address of person who completed cause e of death (Item 23a) (Type, Print) 7 ONES 27035 31. Date filed (A State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address

31. Date filed (Month, Day, Year)

JAN 28

f person who completed cause of death (Item 23a) (Type, Print)

M.D.

7601

32. Registrar's Signature

D26002

OSLER DRIVE TOWSON, MARYLAND

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Month Year 18:24PM bruaru 201 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 49-60-798 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No mone 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "- any injury or other traumatic eventual." 23a or items 23a or ner must be n 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status - American Indian, rces? 2 🗌 No Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 2X No 1 Yes Specify þ Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) College (1-4 or 5+) a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be ည 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street an oute Number, City of Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date Location Burial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) 2011 21. Signatur of Funeral Se vice Licensee 011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician Due to (* as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ancer Examiner Due to (or as a consequence on attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) cancer Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached P.O. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 2 No 3 Probably 4 Nnknown Completed page 2 should пеес 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv performed this certificate 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 2 No 1 Tes Inpatient ည 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of De th n 24 hours atter ueau... ne Funeral Director: After the 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier (check only 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who c pleted cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 28 201

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BROK :30 AM Medical AN 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BALTIMORE MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Hours Director Usual Residence of Decedent show 10a. State other traumatic event, the Medical Examiner must be notified at 10c City, Town or Location Completed by Funeral Director 10d. Inside City Limits 28a-f KaltiMore 1 Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. (Give kind of work done during most of working life. DO NOT Elementary/Seconday (0-12) College (1-4 or 5+) elder Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type) 19b. Mailing Address (Street and Number item 20b. Place of Disposition (Name of cemetary, crematory, or) other p 20a. Method of Disposition Department of I Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses V 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the sode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has 2 No 2 1 Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation Could not be 2 No completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 M.D. JAN 20th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AMIT BANSAL 5601 LOCH RAVEN BLVD

State Registrar

Records,

Division of Vital

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15a ZUII MAIKS 1:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 113 LUIN Sukesulle Howard If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Ye March 26 **Funeral** 9. Birthplace (State or Foreign 1 □XM 2 □ F Mir Hours **Director** Country) 216-44-6110 61 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2v No Howard Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1134 Taylor Park Road Svkesville 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ t. Page 1 and 2 should be 1 thent of Health and Ments thant. If item 27 is marked ijury or other traumatic e Charles Baker, Jr. Gladys Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Baker, IV (son) 931 South Potomac St., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) All County Cremation | Jan.26,2011 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel MOBIL PO Box 195, 6416 Sykesville Rd., Sykesville, MD21/84 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ OP disease or condition resulting in death) Veacs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? likely Mass 1 4 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 ANG 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 🔲 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Chesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

JAN 28 2011

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32. Registrar's Signature

#110 Elesburg

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 26, Physician/ Jeanette Holland Brawner January 2011 9:48 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Gilchrist Care Center Towson Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Dec. 15, 1922 Richmond, VA. 88 231-18-1453 Director Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director be notified 28a-f 1 Yes 2 X No Maryland Baltimore County Cockeysville 23a or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 York Road 21030 United States Examiner must "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 3 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) N/A Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard H. Holland Isabel Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alison B. Warfield (Dau.) 1333 Glencoe Road Glencoe, Maryland 21152 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State (Harford County) 20b. Place of Disposition (Name of Friday Evers Fure at Charles and Jan. 28,2011 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services, Inc. Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Pencertial Alternatives Fureral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 Lic #M00677 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dernent 1DUV Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Month Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Levebrovascular 'Se 40 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 110561CF 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 \square Pending work thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 1 Tes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sig

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faltmore,

MIH 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G912 2/01/2011 III State of Maryland Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 19 7:35 AV 5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner USA Union Hospin Balkmore MO Memoral 21218 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 9, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖈 F Country) Marviand **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 ☐ No **Baltimore Baltimore City** Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral U.S.A 817 Lyndhurst Street 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State Of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) Medical Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Williams Israel Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Harlem Avenue Baltimore, Maryland 21216 Michelle Rollins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Windsor Mill, Md. 01/25/11 King Memorial Park 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility any Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ espiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying for use as the burial-transi Cause (Disease or linjury Cancer Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Other (specify) signed by the a 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 III Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy perform 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗷 No ၉ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7:50 129-505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 2016 University Pkny Baltimore MD 21218 Weinberg MD (Month, Day, Year) N 2 8 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $20\overline{11}$ Edward 11:31A M Bandelin, January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days (Month, Day, Year) 05/07/1947 Country)
Maryland Director 216-48-2116 63 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 X Yes 2 No MD Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 1415 Overlook Way U.S.A. 21014 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify. Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Firefiahter Municipal Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be ment of Health and Ments Bernard G. Bandelin Wanda Grudziecki Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Maureen Bandelin / Wife 1415 Overlook Way, Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 a
Department of H
Important; If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 01/25/2011 Hanover, Maryland 21. Signature of Funeral Sprice Locensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of cor shock, or heart failure. List only of complications that caused the death. Do not eater the mode of dying, such as cardiac or 📂 piratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a sonsequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMA! F: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 🗀 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina Accident 🗌 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 29b. Signature and title of 29c. License number 29d. Date gigned (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) State Registrar

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	neral ector		5. Social Security Number 6. Sec. 219-38-0946		(In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country)		
aryland	fied at	Director	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town or Lo					10d. Inside City Limits		
with the M	st be not		10e. Street and Number 3407 Elmora Avent	10	Datemo	10f. Zip Code 21213			10g. Citizen of What	1 X Yes 2 □ No Country?		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho	caminer mu	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 X Yes 2 No		Was Decedent of His If Yes, specity Cubar	n, Mexican, Pue	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, /hite, etc.		
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", o	Medical Ex	Completed	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest grave)	Year or Dates. ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done du O NOT use retired)	tion	orking	Specify:	Black ess Industry		
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Marylar Should be 1 and Ments 7 is marked	umatic e	ည	James Arthur 19a. Informant's Name/Relationship (Type				Ida	Jane	McCh City or Town, State,			
of Health	r other tra		Pamela Myers / S: 20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo	Browning	g Drive			e, MD 21221		
Baltimore, permit. Page 1 and Department of Hez Important: If item	any injury o once.		4 🖾 Donation 5 🗆 Other (Specify, 21. Signature of Oneral Service Licence)	Anatomy Gif	ts Registry	01/2	25/2011 Datomy Gi	Hanover, fts Regis	Maryland trv		
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<u> </u>		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):	0				3		
Box 68760 death certificate be executed attending physician and	burial-trans	sal Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
68760 sertificate b nding physic	ise as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant 2	i	pregnancy							
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dS, P.O quires that then the en signed by	ould be det	2	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause give	n in Part I.			to the cause of death? Probably 4 🗹 Unknown		
DIVISION OF VITAI RECORDS, P.O. BOX 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Funeral Division of the this certificate has been signed by the attending in the control of the funeral price of the funeral p	page 2 sh	Completed						24a. Was ar autops perform 1 \(\sum \) Yes 2	y prior t ned death	autopsy findings available to completion of cause of ?		
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DIVISION ital or Attendin urs after death. ral Director: Aff	lled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	Specify)			City or Town,	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
thin 24 hor thin 24 hor the Fune	приетеа п	Med	29a. Certifier 1 (Check 2 Medical Examine only one) 3 Certifying Nurse 29b. Signeture and fittle of certifier	r; On trie basis of exam	IIDATION AND/OF INVESTI	gation, in my opinion, eath occurred at the t	death occurred ime, date and pla	at the time date are	d solono and due to the			
	8		John S.	Lahi	m.D.	29c. License n		ده (۵	ed. Date signed (Mor	nth, Day, Year)		
	()	L	30. Name and address of person who cor	npleted cause of death	Raver Be	int) ealevard	Baltim	re Marci	land 212	18		
	State jistrar	3	JAN 2 8 2011	32. Registrar's	Signature	- 7/		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend items 20a-c per fh g912 2-11-11

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Herman Theren Baughman Jr. 2. Date of Death 3. Time of Death Physician/ Dav HERMAN THEROM BAUGHMAN 1210AM JANUARY 2011 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL HARBOR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Country) 0472271943 67 MD **Director** 214-40-6441 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21226 USA 23a Funeral 1501 Locust St. items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 24 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White If Yes, Give "natural", 3 Widowed 4XXDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Security 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman T. Baughman, Sr. Ermal Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3173 Bero Rd., Baltimore, MD 21227 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Genevie E. Smith / Sister Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery cremetory or other place)

Arundel Crematory 01/31 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): DECUBITUS VILLER INFECTED FEM-POP CRAFT, URINARY TRACT INFECTION Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter in the past 12 months? 1 ☐ Yes 2 ☑ No for Day Year Pregnant at time of death 1 ☐ Yes ≥ № 9 ☐ Unknown detached 9 Unknown P.O. s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, CONGESTIVE HEART FAILURE HYPERTENSION certificate has been Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an DIABETES MELLITUS ANEMIA autopsy page 2 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No iniury 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JKgandh MD RES ODOI JANUARY 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GANDHI 3001 SOUTH HANOVER STREET, BALTIMORE, MD-21225 31. Date filed (Month, Day, Year) 32. Residue Signature State parke Registrar IAN 28 2011 Cherry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26/2011 Vadonia Mae Cox 2:29 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 5. Social Security Number **Funeral** . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Months Days Hours Director 1/2/18/19/24 Yrs 229-20-2392 86 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carrol1 1 Yes 2XXNo Eldersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 1601 Homeland Dr., Unit 1D USA 72 hours after death 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: "natural", 3 ■Widowed 4 □ Divorced Completed Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ll Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Claudius Linwood Payne Annie Elisabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Christine Valdes/Daughter 6305 Oklahoma Rd., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 5 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State ò injury 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville UMC Cem 1/29/2011 Taylorsville, MD 21. Signature of Funeral Se Burrier of Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Bilateral disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, heading to him ediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consecutario Exami signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Pregnant at time of death Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dity Rp, Chronic Renel Droeuse Sea 1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown in-chronic, Osteourthurtes, Osteoporosi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Harvalbunenema, Deconderin performe this certificate Yes 2 No s case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred **A**Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident in 24 hour.
the Funeral Direc. Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 3 Certifying Nurse Practioner death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 30. Name and address of pe tem 23a) (Type, Print)

State Registrar HereusenBo

Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

now 2 horrest hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a per np,g913,03/2011dhb.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Louise Covey January 2:35 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Genesis Eldercare Nursing Home Severna Park Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 213-34-6374 91 Months Hours 3 - 30 - 19 19 Maryland Director Usual Residence of Decedent show er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 403 W. Ordenance Road USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired)
Secretary al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 12 Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Truman PRice Daisy Lecklher Lecklieter 19a. Inwini i Name/Politionship (Type, Print) Bill Covery (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2237 Melvin Drive Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 NBurial 20 Cremation 3 Removal from State Meadowridge Memorial Park 1/25/11 Elkridge, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee Gary End Araufmany Funeral Home at MMP, Inc. 7250 Washington Blvd Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Clostriduim difficile Approximate Interval Between Onset and Death Immediate Cause (Final Dementice Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Multi system organ failure Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 1 Yes 2 No certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's 2 No Hospital: Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.

The Funeral Director: After the funeral filled in by the funeral filled in the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directol completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) deuter colony Drive Unnapolis, nun 31. Date filed (Month, Day, Year) State JAN 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Spe		Wes		Cemetery		24-2011		theville	
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	State Registra	-	JAN 282	32. registrar	s Signature	bar	Ked		,		0	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Jan Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MediCAL tim 0 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1**X** M 2 □ F Days (Month Day, Yea 81 Director 212-26-6339 Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Harford Perry Point Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21902 361 Boiler House Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 ☐ Married 1X Yes If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Beverly (unk) (unk) James Vinton Cullum Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 458 Battery Drive, Havre de Grace, Maryland 21078 Rosemary Preston / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or ot St Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2011 Owings Mills, Maryland Garrison Forest Cem. Juneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 WUnknown Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No certificate ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 20il Name and address of person who completed cause of death (Item 23a) (Type, Print) xaltimo Re 31. Date filed (Month, Day, Year) sistrar's Signature State Registrar J DHMH 17 Rev 7/2009

11-00655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Chester Coo	1	I- For State	state of Maryl	and / Dep	partment e	of Hea	alth an			giene		201	01773
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. In Medical Examiner must be notified at once. To Re Commission by Erman Discorber.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio	on 3 Removal fr		Place of Disper- crematory or of			metery,		ate	20c. L	ocation - City o	or Town, State
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lox 6 eath ce attend for use		<u> </u>	known	ant at time of d	eath 5 🗌 c	ther (Spe	ecify)				- 1		
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The state of the s		Victor Weedn MD JD	Assistant Me	-		V. Baltin	nore St	reet, Balt	imore,	MD 2122	23	. —	
State Registra	9 3	1. Date filed (Month, Day, Year)	3 2011 32.	gistrar's Signat	ure ba	Mal	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year telle Curacio Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N Q M V S + 5. Social Security Number Musice 7. Age (In vrs. last birthday) If Unde 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🕅 F Months Davs Hours Min (Month, Day, 3–3–1924 Director 212-46-9644 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4614 Norfolk Avenue 21216 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifiAfrican-American 3 1√2 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Telemarker World Connection Travel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rice Meice Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah D. Green/Daughter 4614 Norfolk Avenue, Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cemetery 1-27-2011 Baltimore, Maryland ure of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. anda 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedected for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \bigcirc No 3 \square Probably 4 \square Unknown been signature should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I alin by the funeral director, page 2 s autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Dis completed filled in Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vardie

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 28 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Milton Cason January A_M 4:45 26,2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death **Timonium** 4c. County of Death Stella Maris Hospice Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 217-68-0038 Months Director 55 Yrs. November 11,1955 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any onee. 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Harford MD Bel Air 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1112 H Vanquard Way 21050 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 X Never Married 2 ☐ Married Black, White, etc. 21215-0036 Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced white Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired). Antique Dealer 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Antique Buisness 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Jane Murphy 2 Calvin M. Cason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 Grafton Shop Road—Bel Air, Maryland 21014 Calvin M. Cason-father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evafis Furgeral Chatelpland Crenation Services Briair Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Fyans, Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Ph_sician/ disease or condition ESOPHAGEAL CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any hadding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Dut to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Day Year 1 Yes 2 G cate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy performed? Yes 2 X No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No ၉ 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred X Natural 5 Pendina s after death. Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined building, etc. (Specify) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Mgnth, Day, Year) 30. Name and add of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

JANUARY

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month 10:59 PM largaret Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Mes 1timore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 📮 F (Month, Day, Year) Months Days Hours Min Director 218-74-9248 Oct 17, 1960 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Cinnamon Circle 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced Specify Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည H. Clifton Corbin Barbara Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Queen 2464 Vineyard Lane Crofton, Maryland 21114 permit. Page 1 and 2
Department of Healt
Important: If Item 2
any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/25/11 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 21. Sign dur f Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ Stroke disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for es a nor se quence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusing and been signed by the attending physician and should be detached for use as the burial-transit Weeks epean that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 No Month Day Year 1 Yes 2 N 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 hypertension, Necrotic extremities Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' ☐ Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending iours after death, neral Director: Ai filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practionar: It the post of my knowledge poets arrowed at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) AU4176435K19755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Zachary

31. Date filed (Month, Day, Year)

Baltimore,

5

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Melvin Clopein 2011 6:05 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 Deer Run Ct. Unit D Halethorpe Baltimore 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Year 11 26, Months Days Year) 219-32-1922 Director 75 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho by Funeral Director 1 Tes 2 No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Deer Run Ct. Unit D 21227 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc. 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the Baker Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Clopein Katie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Marie Clopein-Wife 20 Deer Run Ct. Unit D Halethorpe MD 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetary Jan. 28, 2011 Baltimore Maryland 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of neral Service Licenses 2719 Hammonds Ferry Road Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AHCER WEAR he disease or condition resulting in death) OF Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 - No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 🗹 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ATTEN DING D16200 JANUARY 25,2011

State Registrar 31. Date filed (Month, Day, Year)

NORBERTO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. MACHIRAN, M.D.

AN 28 2011

S. Sares

720-C MAIDEN CHOICE KA. CATOWSVILLE, MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary					Mental Hy				
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate	of Dea	ath	T	Reg. No.					
	Physicia	ın/	EDWARD, A, DE	EVALLE HAL					2, Date of De Month	Day	Year	1	e of Death
	Medic Examin		4a. Facility Name (if not institution, give str			4h City To	wn orloc	cation of Deat		2-(Z ⊃ \\ y of Death	11	: 28 A M
	LABITITI	CI	University of MARY		AL CENTER					N/	,		
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	rs. last birthday)	If Under 1		Under 24 Hrs		rth			te or Foreign
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	nd how at	 	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation						I0d. Inside	e City Limits
	faryla Ba-f s tified	Director	MD N/A	<u> </u>		Balt	imor	ce				1 x	Yes 2 No
	the N		10e. Street and Number	<u> </u>		10f. Zip Ce				10g. Citizen of	What Cour	ntry?	
	n with	Funeral	2243 Annapolis I	Road		2	21230	00		U.S.	Α.		
	death r item ner n	Full		Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent If Yes, specify	t of Hispai Cuban, M	nic Origin? (S 1exican, Puerl	pecify Yes or No- o Rican, etc.)	14. Ra	ce - Americ		,
2000	after al", or xami	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 X	□ No S	pecify:		Specify			
ž	hours natura ical E	Completed	15. Decedent's Educ	cation	16a. Dece	edent's Usual C	Occupation	n		16b. Kind of E			
2	in 72 e. nan "r	ш	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	life. I	e kind of work o DO NOT use re	etired)	_				,	
7	withi		9th Grade		Car	wash	atte	endant	-	Ritchi	e Hg	wy (CarWas
2	e filed tal Hy ed ott	To Be	17. Father's Name (First, Middle, Last)				- 1		me (First, Middle,		ne)		
Š	uld but Mer mark		Edward Devaughn	2:-	<u> </u>				E. Bias				
<u>Z</u>	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. The and Mentel Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type		1	-			ad, Ba 1	-			3.0
บ์	Heal Heal Hean Hean Other		Armentral Cromes 20a. Method of Disposition		b. Place of Disp	osition (Name	of .	l ROE	Date	20c. Location			
Dallillo	permit. Page 1 a Department of the Important: If its any injury or of once.		1 🔀 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cre	ematory or othe		01	/27/11	ŀ	•		
	mit. P partm portal / injul		21. Signature of Funeral Service Licensee			Name and A	Address of	Facility				<u> </u>	
Ŏ	permii Depar Impor any iri once,		JUSTON STORY		i	2148 ^e 8	h Hi	ilerov	vn Jr. Ave.,	Baltin	ore,	me J	² <u>2</u> 1217
			3a. Part 1. En er the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not en	ter the mode o	of dying, su	uch as cardiad	or respiratory ar	rest,		Approxi	mate Between
F	Physician/		In mediate ause (Final dise or condition	Preumor	na								nd Death
	Medical Examiner		resulting in death)	Due to (or as a con-									
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S .	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pre	Fetal death 3	Ectopic pre				1	ate of delive		Year
2	e deal the at hed fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time g ☐ Unknown	of death 5	Other (speci	ify)			IVI	onun	Day	rear
<u>;</u>	nat the		Part II. Other significant conditions contri	ributing to death but no	t resulting in the	underlying cau	ıse given ir	n Part I.	23e. Did t	obacco use con	tribute to th	ne cause o	of death?
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ָׁ נ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	29a. Certifier 1 Certifying Physici	i an: To the best of my kr	nowledge, death	occured at the	e time, date	e and place, a	i and due to the ca	use(s) and manr	ner as state	d.	
:	ne Ho in 24 I he Fui pletec	Med	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	On the basis of examin	ation and/or inve	stigation, in my	opinion, de	eath occurred	at the time, date a	and place, and du	ie to the cai	use(s) and	manner stated.
1	vithi To t		29b. Signature and title of certifier			-	icense nun			29d. Date signe			
	'n		Vinux & Just	MD PGY-L		159	8080	0186		1/21/2	011		
	2		30. Name and address of person who com	pleted cause of death (ltem 23a) (Type,	Print)	10 h		1-1-6-				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\mathsf{Day}}{2} \underline{4}$ Physician/ 2011 Annie Elizabeth Dustin January 10:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15520 Riding Stable Road Montgomery Laurel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours (Month, Day, Year) ine 20, 1921 89 Director 218-16-0468 Yrs June Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Montgomery Laurel ò 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 15520 Riding Stable Road 20707 USA items ? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", or the Medical Exan 1 Yes 2 No Specify: White 3 Widowed 4X Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Dry Cleaners Seamstress Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas B. Connell Grace A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Thomas Dustin/Son 16813 Clark Terrace, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1/29/2011 Laurel, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M01103 23a. Part 1 Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Squamous cell carcinoma of Tongue Stage III disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Anemia, Pneumonia, COPD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending after death. 2 Accident 1 Tes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practic per: To the best of my knowledge death and an active time date and place and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) アンシ D 30573 しー スメーリ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Drive, Suite G020, Columbia, MD Jon Kent Minford, 31. Date filed (Month, Day, Year, 32. Registrar's Signature JAN 28 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 2011 рм Diegel 08:25 Marion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Overlea Health and Rehabilitation Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. 0972371920 Director 212-12-5418 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director notified 1 X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code r items 23a or iner must be n ò 10g. Citizen of What Country? Funeral 1651 E. Belvedere Avenue U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No Was Decedo... Armed Forces? ¹ ☐ Yes 2 🔀 No 14. Race - American Indian, the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ ō 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify "natural", Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Greetings & Readings Cashier other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Frank Magri Matilda Bianco t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Nodleigh Terrace, Jarrettsville, MD 21084 <u>D</u>iana Weber, Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Dulaney Valley Memorial Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 01/28/2011 . Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ coronar disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any leaving cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consquence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and red filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No ☐ Yes 2 🐼 No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 🔊 No Hospita Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State DHMH 17 Rev 7/2009

Registrar

29b. Signature and title

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaven

Blud

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year), Tonuary 25th 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dabrasky Timothy Shou1 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Maryland 10301tal XìMOIC If Under 24 Hrs. . Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F (Month, Day, Hours Min. 218-62-9533 51 **Director** 5,1959 Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No N/A 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21223 USA 1817 Wilhelm Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White 3 ☐ Widowed 4X Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Window installer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shirley Lou Pailer Gilbert William Dabrasky Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Wilhelm Street, Baltimore Maryland 21223 Cheryl Dabrasky - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.29,2010 Glen Burnie Maryland Atlantic Crematory 21. Signature eral Service Licens 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Hammonds Ferry Road, Lansdowne Maryland 2122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Du to (or as a consequence of signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 24 hours after death. Funeral Director: After this certificate 2 🗌 No Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ertifying Physicfan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier signed (Month, Day, Year) MD. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State ack 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25,201 R Dellinger January 1:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7952 Oakwood Road Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**☐M 2 ☐ F Hours sept. 1, 1940 Lowe 11 Director 225-54-2596 70 Usual Residence of Decedent 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7952 Oakwood Road 21061 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemany injury or other traumosts. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

XX Yes 2 \sum No Black, White, etc. by 1 Never Married XX Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Military Software Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luther C. Dellinger Elsie Mae Rilev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7952 Oakwood Road Glen Burnie, MD 21061 Mrs. Kathryn Dellinger / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 27 cemetery, crematory or other place) 1 ☐ Burial XX Cremation 3 ☐ Removal from State 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Services icensee 22. Name and Address of FacilitySingleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line. 23a Part or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician. 5 St disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Xyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital or Attending Physician; The law requires that the death certificate be executed After this certificate has completed filled in by the funeral director, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At

0

State

DHMH 17 Rev 7/2009

Certificate:

Medical

27. Manner of Death

Naturai

Accident

3 Suicide 4 Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifier

Ďay,

5 Pending

Investigation

determined

8 2 JAN

6 Could not be

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

305

work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28d. Déscribe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

26

201

2106

28a. Date of injury (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JAN Physician/ 6:49 P M 23 KALIE DUNCAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY **BETHESDA** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday, 8 Date of Birth Month, Day, **Funeral** Days Min Months Hours 1 M 2X F Maryland Director Jan none Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 😾 No Maryland Laurel Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20723 United States 10113 Summer Glow Walk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. ģ 1X Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White/Asian-Indian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of the control of the contr (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) n/a Never Worked 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ည Mona Deora Marten Boyd Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marten Boyd Duncan/father 10113 Summer Glow Walk Laurel, Maryland 20723 t of Healt : If item ' / or othe Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/26/2011 Woodbine, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Lice M00957 Heckrotte, P.A. Clarksville, MD Beverly L. Thomas Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition EXTREME PREMATURITY Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate come. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 No the detached g Unknown ned by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign(Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has performed? 1 Ves 2 No 1 🔲 Yes 2 X No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No **Division of Vital** 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 \(\sime\) Yes 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death. Funeral Director: A the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0101247915 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 CPT MC USAF KRISTEN ZELIGS 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JAN 28 2011 racked Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Doe 1030PM 01 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> 15215 Barnesville Road</u> <u>Boyds</u> Montgomery 7. Age (In yrs. last birthday) If Under **Funeral** 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Hours Jul 27 ^{Year} 1924 New Jersey 140-14-0436 Director Yrs. 86 Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 🗌 Yes 2 😾 No Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15215 Barnesville Road 20841 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick **Ambrose** Sharkey Mary Mathilda Parfitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15215 Barnesville Road Christine DeReggi/grand-daughter Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/27/2011 Woodbine, Maryland 21. Sign to e of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) heart failure Heave Medical Due to (or as a consequence of). Examiner years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 2 🔀 No 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After 1 28d. Describe how injury occurred 1 **S**Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide hours after death ieral Director: A filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 1-25-2011 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rockvolle, MD 20850

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32. Registrar's

Coleman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AWSON 10:21 AM 1Atthew 201 Medical TAX 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Medical Center Polis THAA If Under 1 Year If Under 24 Hrs. Funeral 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2 □ F Months Days Hours Min. Month, Day, Year Country) 68-6347 Director tAh Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Devern 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 USA DICUS 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc., Armed Forces' 1 Never Married 2 Married Yes 2 No δ 3altimore, Maryland 21215-0036 1 ∟ Yes . If Yes, Give 1 Yes 2 No Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Employed onstruction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, GAlen AWSON Evelyn Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE WIFE 135 1) AWSON Dicus mill Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State HAnover, MI Ardent Cremation Ser 4 ☐ Donation 5 ☐ Other (Specify) 1/26/11 22. Name and Address of Facility HACTY H. WITZKE'S FAMILY FH INC 21. Signature of Funeral Service Licensee 4112 Old Columbia V Ellicett City MD 1.Ka 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -forhageal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 anding pro IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 5 Other (specify) Yes 2 ☐ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X N cate has page 2 s 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide n 24 hours after death be Funeral Director: / bleted filled in by the I Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Franticiner: To the best of my knowledge due to account of the time date and place, and due to the cause(s) and member as stated. (Check 29b. Signature and title of D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway anapolis Des perd Bech, M

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Syble Priscilla Elmore January 27 3:15 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours October 2 North Carolina **Director** 238-38-3938 83 Yrs 7927 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Frankford Delaware Sussex 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 19945 37185 Georgia Drive USA items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)

CONTROLLER and Mental Hygiene. is marked other than Elementary/Seconday (0-12) **9**ollege (1-4 or 5+) Continental Can Co. Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname)

Mary Smith ပ Lee W. Melton Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Elmore/Husband 37185 Georgia Drive Frankford Delaware 19945 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)

Moreland Mem. Park 1 X Burial 2 Cremation 3 Removal from State 1/29/11 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Vital or Attending Physician; 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2/1 No 1 🗌 Yes Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after deal To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIL 0064120 2011. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Zecshan AUH 9733 Health Wa AaH 9733 Health way Drive Berlin M'D 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 Registrar

DHMH 17 Rev 7/2009

11-00477 Charles Eney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

manes Li			1- For State Registrar	Certificate o	of Death		g. No.	0178
Ph Medical E	ysici xami		Decedent's Name (First, Middle,Last) CHARLES ENEY			2. Date of Death Month January 17		3. Time of Death 0930 hrs
			4a. Facility Name (if not institution, give street and number 1701 Eutaw Place Apt. 621)	4b. City, Town, or Location of De Baltimore		4c. County of Death	
Fur	neral			ge (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birt	N/A	hplace (State or
Dire	ctor		217-40-6790 1XM 2 F	66 Yr	Months Days Hours M	03/11	/1944 Foreig	·PYLAND
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits
land	28a-f show I at ouce.	힏	MD N/A	BALTI	MORE			1 X Yes 2 No
he Mary	or 28a	Directo	10e. Street and Number 1701 EUTAW PLACE APT.	621	10f. Zip Code	10	g. Citizen of What Coun	itry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene.	De not		11. Marital Status 12. Was Deceden	t Ever in U.S. 13. W	21217 as Decedent of Hispanic Origin? (can Indian, Black,
er death	, or ite	Funeral	I Never Mairied Z Miairied	No	Yes, specify Cuban, Mexican, Pue Yes $2 X $ No specify:	nto Rican, etc.)	White, etc.	ITE
ours aft	xamin	d by	15. Decedent's Education (Specify only highest grade cor	mpleted) 16a. Decede	ent's Usual Occupation (Give kind on nost of working life. DO NOT use in		Specify: WH 16b. Kind of Business/Ir	
36 in 72 h	sarked other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	SALESMAN	etired)	WINE	
5-00 led with	other t	Com	17. Father's Name (First, Middle, Last)			me (First, Middle, M		
21215-0036 uld be filed within 7 Mental Hygiene.	Important: If item 27 is marked o injury or other traumatic event, th	To Be	CLARENCE LLEWELLYN 19a. Informant's Name/Relationship (Type, Print)	ENEY	BETTI		THOMPSON	
MD d 2 shoulth and I	umatic		LISA ENEY/ SISTER	9	LINWOOD AVEN			21224
of Heal	If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from St	20b. Place of Dispos	sition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of He	y or of		4 Donation 5 Other Specify: 21. Signature of Eunegal Service Licensee		CREMATORY 1/	20/2011	BALTIMOR	E, MARYLAN
Ba Perm Depa	i.				Name and Address of Facility LILLY & ZEILE 1901 EASTERN	ER INC. AVENUĖ,	FUNERAL H BALTIMORE	OME ,MD 21231
Physic			23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter t	the mode of dying, such as cardiac			Approximate Interval Between Onset and
xam	iner		Immediate Cause (Final disease or condition resulting in death) a. Methad Due to (or as a const	one Intoxica equence of):	ation			Death
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a constitution)	edilence of).				
	-	Examine	cause. Enter Underlying Cause (Disease or hijury that initiated					
Secured &	and transit	Ë	events resulting in death) Last Due to (or as a const					
0 ,	hysician a e burial -	Medical			per me g912 2-9-	-11 vt	HEE & C =	
5876	attending phy for use as the	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor	2 Fe	etal death 3 Ectopic preg	inancy	23d. Date of delivery Month Da	ay Year
30X (death or	the attended for use	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5 Ot	ther (Specify)			
D. O. I	ed by letach	by Ph	Part II. Other significant conditions contributing to deat	h but not resulting in the (underlying cause given in Part I.		acco use contribute to the	
ds, F	sen sign	eted t				Yes 24a. Was ar	2 No 3 Proba	ably 4 ✓ Unknown opsy findings available
COL	e has b ge 2 sho	Comple				autops:	prior to co ned? death?	empletion of cause of
<u>8</u> 32	certificate ector, page	Be Co	25. Was case referred to medical		26.Place of Death (Chec			
f Vit	er this c	유	1 Tes 2 140	ent 2 ER/Outpatient			esidence 6 🗸 Other:	Scene
OD O ending ath.	he fune	ţi ii	1 Natural 5 Pending (Month, Day, Y		1 You 3 T No	unknown	w injury occurred	
VISION Att	Director I in by t	Certification:	3 Suicide 6 X Could not be 28e. Place of In		et, factory, office building, etc.	28f. Location (St	reet and Number or Rura	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	'uneral	- 1	4 Homicide determined (Specify) 29a Certifier 1 Certifula Physician: To the best of m	residence	grad at the time data and also	Baltimo	re City, Md	. 21217
To the H within 24	ompletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.					
F *	P 5	ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
0	A		30. Name and address of person who completed cause of d	leath (Item 22a)	O.C.M.E.		January 18, 2011	
.80	N		Laron Locke MD. Assistant Medical Exa	aminer 900 W. Ba	altimore Street, Baltimore,	MD 21223		
P	St egist	ate	31. Date filed (Months, BayyYear) 32. Registra	r's ignatur	· · · · · · · · · · · · · · · · · · ·			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 9911 1-28-11 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 20 IT Foard Charlotte 9:01 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Elkridge Howard 5771 Old Landing Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Director 220-60-8448 58 Mary land Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Elkridge 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6028 Bakers Place 21076 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles W. Heinbauch Mary Elizabeth Hiers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Heinbauch/ Father 1205 Furnace Road, Linthicum ,MAryland,21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Competers, crematory or other place)
Meadowridge Memorial 1/31/2011 1 Burial 2 Cremation 3 Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service Licensee ^{22. Name and Address of Facility} Gary L. Kaufman Funeral Home, Inc 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that cause one death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician metastaric PANCREATIC CANCER disease or condition MOUTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed Yes 1 🗌 Yes 2 🗌 No 25. Was case referred to medical After this certific funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Australiance 6X Other (Specify)residence ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending ☐ Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) JANUARY 27 2011

Registrar

16

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01789 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 26, 2011 Maria Gertrude Fitzke 5:10 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, 1 □ M 2 🖾 F Days Hours Director 248-86-3609 90 Germany Usual Residence of Decedent 10b. County at 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Medical Examiner must be notified or 28a-f 1 🗆 Yes 2 💆 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 244 Wakely Terrace 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes Give "natural", Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home other Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ be Kaspar (unk) Fussangel Klara (unk) Tepe and lisim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Cable Street, Baltimore, Maryland, 21210 <u>Evelyn C. Fitzke / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o Burial 2 X Cremation Donation 5 1 Other cemetery, crematory or other place) 3 Removal from State Hilltop Service Corp. 2/1/2011 Specify) Towson, Maryland 21. Sign ture of Funer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Neumonia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical pe IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Dav the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?
1 □ Yes 2 □ No autopsy certificate Yes 2 No 25. Was case referred to medical Division of Vital Be B 26. Place of Death (Check only one) examiner? Mari Other: 2 2 No 1 inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 1 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier en 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

K

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ann Muriel Frazier 4:20 A M January 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 220 Bynum Ridge Road Forest Hill Harford Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F (Month, Day, Year)
March 8, 1930 Hours 80 213-28-9497 Director Maryland Heual Residence of Decedent show 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director or 28a-f Maryland 1 🗆 Yes 2 🔀 No Harford Forest HIll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 220 Bynum Ridge Road 21050 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc þ 1 Never Married 2 X Married If Yes, Give Year or Dates Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homeneker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Norman Greenwell injury or other traumatic Anna Muriel Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Matthew A. Frazier (Spouse) 220 Bynum Ridge Road, Forest Hill, Maryland 21050 permit. Page 1 and 2 Department of Health Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🐰 Burial 2 🗆 Cremation 3 🗆 Removal from State January Bel Air Mem. Grads 4 Donation 5 Other (Specify) 2011 Bel Air, Maryland Funeral Service Ligensee Jeffrey R. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 . Signature of (MO1543) Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Galactic
Pregnant at time of death in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perform Yes 2 No 1 Yes 2 No Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 5 Pending 2 No Accident Investigation 2 Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Proctioner. To the best of my knowledge commed at the films, date and place, and due to the cause(s) and marker as stated 29c. License number who completed cause of death (Item 23a) (Type, Print) 2300 1 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilbur Richard Fry 2011 10:00 AM 24 Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 108 Gwen Drive, Unit G Forest Hill Harford County 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 **X**M 2 □ F 146-22-5291 **Director** 930 Clayton, N.J. Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director Maryland Harford Co. Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Completed by Funeral 21050 108 Gwen Drive, Unit G. United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Yes 2 No If Yes, Give 1951-1955 9 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 XNo Specify: Specify: White "natural" 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 College (1-4 or 5+) 5+ within Elementary/Seconday (0-12) Scott, Foresman & Co. 12 Educational Salesman other Be Page 1 and 2 should be filed ment of Health and Mental Hyant: If item 27 is marked oth Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilbur Fry Eunice Lanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette W. Fry (Wife) 108 Gwen Drive Unit G., Forest Hill, Maryland 21050 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2011 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Bel Air Memorial Gdns Jan. 29, Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 2 Name and Address of Eachlily Vans Funeral Chapel & Cremation Services-BelAir Newport Drive, Forest Hill, Maryland 21050 com 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed think 24 hours fairer death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number

State

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Registrar

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann E. Faulkiner - Evans Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Good Sam. Hosp. 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min NC Country) 1 □ M 2 🖾 F Months Hours Director 214-40-8599 68 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director **Baltimore** N/A Exeter traumatic event, the Medical Examiner must be notified MD Y Yes 2 No 10f. Zip Code 21202 10e. Street and Number 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or Funeral 125 S. Exeter St. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces African
Specify: Completed by 1 Never Married 2 Married ☐ Yes 2 XNo 1 Yes 2 X No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Amer. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Social service Elementary/Seconday (0-12) College (1-4 or 5+) Supporter Community and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame)
Ora Lee Carr 17. Father's Name (First, Middle, Last) Thurman Herring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5356 Sinclair Lane, Balt., MD 21206 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Felicia Brooks/Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/28/11 Balt.,MD Zion Cem. 4 Donation 5 Other (Specify) Signature of Funeral Savice Licens 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to for as a consequence of: Approximate Interval Between Onset and Death Physician/ Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 Yes 2 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number MD D0069314 -1-22-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waltham Woods R& Parkertle MD 8813 Year 2 31. Date filed (Month) State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Kathleen Mae Ferguson 23, January 21:54 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Co. Hospice Dove House Carroll Co. Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours Months 1 □ M 2 K F May 6, 1923 281-22-3008 87 Ohio Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Anne Arundel Co. Brooklyn 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 4904 Kramme Avenue 21225 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo Specify þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 yrs. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Roscoe Shoults Zickafoose Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Wanda Fosler / Daughter 5515 Woodbine Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 1/28/2011 Glen Burnie, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com calons that caused shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence o Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cause (Disease or injure that initiated events resulting in death) Last Due to (or as a consequence of) in/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy past 12 months? Month Year 5 Other (specify) Jnknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 TYes ase referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer mast be notified at once.

altimore, Maryland 21215-0036

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5 Pending

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De Hospit	Division of Vital Records, P.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by	completely filled in by the funeral director, page 2 should be detac	Medical Certification: To Be Completed by Phy	25. Was exan 1 27. Manr 1 2 2 3 4 1
)	n 24 hour ne Funera	pletely fill	edical	29a. Cei (Ch on

rtifier 🛮 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. neck only e) 29d. Date signed (Month, Day, Year) nature Ad title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coutor Stroot Worthwater, Mil 2457 State Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 3. Time of Death Year Physician/ Lillian Fields 8:30 PM January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Seasons Hospice of Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🖵 F Director 213-54-0782 Apr 16, 1950 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8007 Mollye Road U.S.A 21208 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: , 2 should be filed www...
alth and Mental Hygiene.
n 27 is marked other than "natural"
...matic event, the Medical Ex If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore Gas & Electronics Line Person 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucy Fields Joseph Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health s tant: If item 27 i 1335 North Woodyear Street Baltimore, Maryland 21217 Sherman Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/27/11 Lansdowne, Maryland Mt. Zion Cemetery 21. Sign super of Funeral Sarvice Licensee 22. Name and Address of Facility 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate interval Between Onset and Death Immediate Cause (Final Atheroscherotic Cardiorascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami physician and s the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in thin 24 hours after death.

The Funeral Director After this certificate has be the Funeral Director After this certificate has be impleted filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Pother Specify Heart hospice 2 ⊡No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ns Kajapahsem. D 1/21/11 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapa K.Se, M.D. Z835 Smith AV-5-703 - Baltimore, MD. 2/209

Registrar

State

N.S. Rajapakse, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 5:02 PM Linda Marie Frey 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death altimore 110 43nes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Min. Hours 1 □ M 2 🛣 F Months Days 56 217-66-4461 05/08/1954 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 1 No Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 Francis Avenue, Apt. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Donald Keil Delores Sylvia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Frey / Husband 1300 Francis Avenue, Apt. 1, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) <u> Anatomy Gifts Registry</u> 101/25/2011 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bans Loronar Due to (or as a consequent of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery s decedent pregnant 3 Ectopic pregnancy ne past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Yes 2 Z No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be rediffed at

Baltimore, Maryland 21215-0036

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3 Suicide

4 Homicide

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

2

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

within To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January21 Month Physician/ 2011 5:30P.™ Howard Foertsch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Woodlawn Baltimore 7007 Brompton Road If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Mar vland 1 M 2 □ F **Director** 212-26-731 80 an 5 "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director Sparrows Point Baltimore 1 Yes 2 XNo Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21219-2319 Funeral U.S.A. 8607 Northpoint Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) City of Baltimore Fire Fighter Be (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stella ည Howard Foertsch, John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Trowman Lane Mount Pleasant, SC 29464 John F. Foertsch Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem. FEB | ZON Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licer Md.21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 405 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, recomp to immediate cause. Enter Underlying Examine utile to (or as a nonsequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 1 🗌 Yes 2 🔀 No __ Yes 25. Was case referred to medical Living Be 26. Place of Death (Check only one) registed Hospital 1 ☐ Yes 2 🖾 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Funeral L Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of By knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D 58291 January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Osler Drive, Ste.502 Towson, Md.21204 Aminur R. Khan, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 28 Registrar --

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.															
Physicia Ledical Exami		1. Decedent's Name (Cecil Gill		e,Last)							2	Date of De Month January	Day	Yea.	r	3. Time of I 1036 h	
		4a, Facility Name (if r 116 North Pa		· -	number)		41	o. City, T Baltim	own, or Lo	ocation o	of Death		4	c. County o	f Death n/a		
Funeral Director		5. Social Security Nur	mbe unk	6. Sex		yrs. last bir 52	rthday) Yrs.	If Unde Months	1 Year Days	If Unde Hours		8. Date of E	•		Foreign	hplace (Stat n untry) MD	
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ne Maryland or 28a-f show fied at once.	Director	10e. Street and Numb		1/ d			Ī	10f. Zip					10g. Cit	tizen of Wh	at Coun	try?	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland be and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	by Funeral I	11. Marital Status 1 Never Married 3 Widowed	4 Dive	arried Armed 1 Ye proced If Yes, Give or Dates:	Year	No	If Ye	s, specify	Cuban, I	Mexican, specify:	Puerto R	cify Yes or Nican, etc.)		White	, etc. Blac		Black,
5-0036 led within 72 hours after Hygiene. other than "natural";	eted	15. Decedent's Educ			rade complet e (1-4 or 5+)	(ed) 16a.	Decedent's during mos						166.	Kind of Bus	siness/ir	ndustry	
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21215-0036 unid be filed within 7 Mental Hygiene. marked other than cevent, the Medical	Be C	17. Father's Name (Fi									,	First, Middle ee Bal					
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e, MD and 2 sho Health and item 27 is traumati		Gloria Bal 20a. Method of Dispo	sition		Т	20b. Place	of Dispositi	ion (Nam				timor Date				Town, State	
Baltimore, permit. Pages I are Department of Hee Important: If itelingury or other tr		4 Donation 5	Other Sp	3 Remova	I from State	Balti	tory or othe LMORE		nator	ту	01.28	.2011	Ba	altimo	ore,	MD	
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		11. Separature of untal Service Licensee 22. Name and Address of Facility John L. Williams Funeral Directors 4517 Park Hots Ave Baltimore, MD 21215										5	j				
Physician /Medical.		23a. Part I. Enter the failure, List only	disease, or	complications tha	t caused the	death. Do n	ot enter the	mode o	dying, su	uch as ca	ardiac or r	respiratory a	rrest, sh	ock, or hea	rt	Approxima Between	ate Interval Onset and
ixaminer	Ì	Immediate Cause (Fin or condition resulting		a. Intracere	bral hen											De	eath
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	an/M	IF FEMALE: 23b. Was decedent propast 12 months?	egnant in the	e 1 Liv	s, outcome o e birth egnant at time		2 Feta	l death	3	Ectopic	pregnanc	Су	23	3d. Date of a Month	-	ay	Year
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Vital Revysician: The his certificate director, page	Be (25. Was case referred examiner?	d to medical	Hospital:					10	f Death (Check on		7				
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ON O ending sath. or: Afte	tion:																
Division sapital or Attendir hours after death.	Certification:		determined (Specific)									mber, City					
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To the within To the comple	Med	29b. Signature and tit		and manne					License							th, Day, Yea	r)
		Maryera	The	Yhell					O.C.M					nuary 16,		• •	
		30. Name and addres Margarita Kor		who completed c Assistant M			900 W.	Baltim	ore Stre	eet, Ba	ltimore	, MD 212	23				
St	ate	31. Date filed (Month,	Day, Year)		legistrar's S	ignatur	bar	27								 	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 24, 2011 3:25 A M Ingrid Maria Gase Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Year, Jul 16, 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country)
Germany Months Days Hours Min Director 585-32-8144 1938 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a. State 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 W No Columbia Maryland Howard 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 7479 Hickory Log Circle 21045 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Education 5+ High School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tilde Geissler Hans Maier traumatic . Page 1 and 2 should be ment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6429 Spicewind Court Columbia, Maryland 21045 Mark J. Scott/son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/29/2011 Woodbine, Maryland 21. Signal of Funeral Service Lice Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to (or as a tonsequence of): and small ymphocytic lymphonia Ph sician/ a End Stage disease or condition Medical Examiner resulting in death) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f 2 No g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k I be deta 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has autopsy page perform certificate 1 Yes 2 No Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 Yes 2 No 2 Accident Investigation within 24 hours after death

To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier al comp 1/24

Registrar

DHMH 17 Rev 7/2009

State

4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

670, M. Charles

31. Date filed (Month, Day, Year)

JAN 28 2011

Anne lewis

Velanuer,

2120.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:10 PM Raw Griffiths January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Earleville Cecil 785 Knight Island Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F (Month, Day, Year) 09/11/1931 United Kingdom 79 **Director** 170-58-2232 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 Tes 2 X No Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 785 Knight Island Road 21919 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 🔀 Married "natural", or 1 ☐ Yes If Yes, Give 2 X No 1 Yes 2 X No Specify. Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Boating <u>Marine Surveyor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Griffiths Barrington Eric Irene of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 Knight Island Road, Earleville, MD 21919 Sandra Griffiths / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/25/2011 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Fuperal Service Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea Immediate Cause (Final Unknows Physician/ disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending work? 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 1.24.2011 Hochden 5 MT) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2011 6:35 Reynold J. Giese, Jr. Ам 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timenium Baltimore 6. Sex 1 M 2 D F 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 82 Hours April 16 1928 220-22-1812 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🄀 No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 3104 Winchester Way U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? 1 X Yes 2 ☐ No 1946-1 Never Married 2 Married 1 🗆 Yes 2 🔀 No Specify. 1949 If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Information Technologist Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reynold J. Giese, Sr. Bertha Wenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Phyllis M. Giese (Spouse) 3104 Winchester Way, Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 29, 1 \square Burial 2 X Cremation 3 \square Removal from State Evans Funeral Chapel & 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Srvcs. Rel Air 21. Signature of Funeral Service Licenses Evans Fureral Chaptel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 (M01543)23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMORRANGE disease or condition resulting in death) Due to (or as a consequence of): Sequentially that conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last 23d. Date of delivery 3 Ectopic pregnancy. Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760 signed by the P.O. Division of Vital Records, certificate has been si irector, page 2 should director, After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

Physician/

Medical

Director

Completed by Funeral

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

Medical

21215-0036

Maryland

Baltimore,

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence ၉ Certificate: 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 12/25/10 1 Yes am Investigation 6 Could not be 28f. Locat in (Street and Num er or Rural Route Number, 3104 WINCHCSTCH IN AU LA Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hone Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 28 20

11-00613 Harry Robert Hicks			e ase Ty Si	pe or Print ate of Mar	t in B l yland	/ Depa	delible rtment tificate	of Hea	Ith an	e All C d Men	Copie s tal Hy	s Are L giene		201	Ιπιαο
Physician		tegistrar 1. Decedent's Nam	e (First, Midd	lle,Last)		007.	mouto	<u> </u>		-		2. Date of D			3. Time of Death
Medical Examine		Harry 1			II	I						Month January	22, 20	Year 111	1655 hrs
	ľ	4a. Facility Name (if not institution						Town, or more	Location of	of Death		4	c. County of Deat	h
European I	4	5. Social Security I		6. Sex	7 Ac	ge (In yrs. Ia	st birthday)		der 1 Yea	r If Unde	er 24Hrs.	8. Date of	Birth (MN	N/A	rthplace (State or
Funeral Director				1 X M 2				Mont				1		Fore	
		212-98-8 Usual Residence of		I Z W Z	-		29	13.		٠		1 007	037	1901	·· PID
any	r	10a, State	10b. County			10c. City,	Town or Lo	cation		_					10d. Inside City Limits
viaryland 28a-f show any d.at.once.	5	MD		N/A					Ва	ltim	ore				1 X Yes 2 No
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Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "matural", or items 23a or 28a-f shouldury or other fraumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 Never Marri	ed 2 X N		Deceden d Forces	t Ever in U.S						ecify Yes or Rican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Black,
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		Elementary/Sec	ondary (0-12)	Colleg	e (1-4 or	5+)	during	most of wo	orking life	. DO NOT	use retire	ed)			
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21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than ic event, the Medica		Harry R	. Hic	ks Jr.			19h Mai	lina Addres	s (Stree					adows City or Town, Stat	e. Zip Code)
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Baltimore, oermit. Pages 1 and Department of Heal Important: If iten injury or other tra	+	4 Donation 5 21. Signature of Fu	Other Suneral Service		1.	1110.		. Name an	d Addres	s of Facility					
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Physician		23a. Part I. Enter the failure. List or		r complications the on each line.	at caused	d the death.	Do not ente	r the mode	of dying	, such es c	cardiac or	respiratory	arrest, sh	nock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause													Death
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Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate by an interferent. In Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the but its certificate.		Part II. Other sign	ificant condi	tions contributi	ng to dea	th but not re	sulting in th	e underlyir	ng cause	given in Pa	art I.			_	the cause of death?
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Div		3 Suicide 4 ✔ Homicide		uld not be ermined (Spe	cify) Lo	cal Stree	t				4	or Town 100 block	n, State) Swale A	venue, Baltimo	re, MD
Division Bospital or Attend 24 hours after death Fluoreral Director: stely filled in by the		29a. Certifier 1		Physician: To the											
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Purporal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buck this contract of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the purporal physician of the	Medical	one) 2		aminer:On the ba and mann			nd/or investi					the time, da			
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AMEND ITEM# 28a-f, perPHYS, G911, 1/28/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:33 PM January 2011 Jane Edwards Harkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Harford Bel Air 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day Ye 1 □ M 2 🕱 F Davs Hours Min Year) 1937 North Director Nov. Carolina 218-40-0875 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 238 Kensington Parkway 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. à 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 X Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeff Elgin Edwards Ruth (unk) Brookshire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly H. Rhodes / Daughter 2230 Kalmia Road, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Deer Creek U.M.C. Cem 1-24-11 And the of Furnal Service Licenses ²², Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one requised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Primonary DMbolism Physician/ disease or condition resulting in death) 2W hours **.** Medical Due to (or as a consequence): Examiner Cardiogenic hours Shar Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a cons-ouence of): coagulation physician and the burial-transit Disseminated intravascular hours Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical acute myocardial intarchim hous Hospital or Attending Physician: The law requires that the death certificate be 68760 signed by the attending plants and be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery yes, outcome of pleghancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) Unknown Box in the past 12 months?
1 ☐ Yes 2 🕱 No Month Dav Yes 1 ☐ Yes 2 ⊑ g ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure renal Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown respiration 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred I Director: After the funeral Natural Accident 5 Pending Found unresponsive KNOWN 1 Yes 2 Ho Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Upper Chesa pecike outpatient Lab within 24 hours at

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January, 18,2011 D0065421 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chesapeake Drive, Bel Arimo 21014 Christa Fistler, MD 500 upper 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Harkins,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Racquel Tval 3. Time of Death 2. Date of Death Physician/ Day Month Tracey-Ann Harvey 5:30A M January 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4600 Deblin Circle Dikesville Raltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** (In yrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 XF NIA 33 Jamaica Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10d, Inside City Limits **Funeral Director** MD Baltimore Pikesville 1 Tyes 2 No 10e. Street and Number 10g. Citizen of What Country? 4600 Dedin Circle, Apt. D Jamaica 12. Was Decedent Ever in U.S. Armed Forces?... 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Hack 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking ustomer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherul Clarke Christie Mother MD 21208 4600 Deblin Circle, Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 0207 2011 Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Vaughon C. Greene Frineral SUCS 22. Name and Address of Facility 8728 L ibertu Road Kandallstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. retail documents Pregnant at time of death Unknown 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 12 No 9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by breast 1 ☐ Yes 12 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical

Division of Vital Records, P.O. Box 68760

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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lauw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

401 n. Broadway, 2m 1363, Baltmore MD 21231 wenyyawo

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruby S. Haire Month 6:05 A Medical January 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Hours 242-12-3834 Director 87 1923 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Baltimore MD Timonium 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 306 Quaker Ridge Road 21093 United States : If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) 12 nd Mental Hygier marked other t Teacher Be 」 A M M Maryland Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Peary Sexton Nola Holdsclaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Haire/ Son 306 Quaker Ridge Rd. Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Evants refuneraliace) Chapel - Bel Air Januatry 1 Burial 2 X Cremation 3 Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 27, 2011 Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 /23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ ease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 角ルタイ 中外 たら Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknow To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide iniury 5 Pending 2X No 1 🗌 Yes 11 loam Investigation Tace o Injury - At home, farm, street, factory, office building, etc. (Specify)
BATHLOOM BY NULSES 6 Could not be 4 Homicide 28f. Loca in (Street and Number or Rural Route Number, determined 300 DUIA NULSES STATION Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar

1,059m

32. Registrar's Signature

11-00650 Steven Hammen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificat	e of Death			j. No.	
Physicia	in/	Decedent's Name (First, Middle,Last)				2. Date of Death Month	Day Year	3. Time of Death 0945 hrs
Medical Exami		STEVE	HA	MMEN	vn, or Location of	January 24	, 2011 4c. County of Dea	
		4a. Facility Name (if not institution, give street and number) 4209 E. Lombard Street		Baltimo	·	Death		ORE CITY
Funeral	-		In yrs. last birthd	ay) If Under	1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or
Director				Months	Days Hours	Min.	Fore	eign NYVLAND
,	-	214-58-9757 1 X M 2 F Usual Residence of Decedent	57	Yrs.		02/24	/ 1955 F.	IANT LAND
any			Dc. City, Town or	Location				10d. Inside City Limits
≹ "		MD N/A	ВΔТ.Т	IMORE				1 X Yes 2 No
te Maryland or 28a-f show fied at once.	윉	10e. Street and Number	<i>D11</i> D 1	10f. Zip C	ode	10	g. Citizen of What Co	ountry?
or 2	Director	4209 E. LOMBARD STREE	Ψ		21224		U.S	.A.
72 hours after death with the Maryland n "natural", or items 23a or 28s-f sho al Examiner must be notified at once.		11. Marital Status 12. Was Decedent E			of Hispanic Origin	n? (Specify Yes or No-	14. Race - Am	erican Indian, Black,
leath r iteu	Funeral	1 X Never Married 2 Married Armed Forces? 1 X Yes 2	No	It Yes, specify	Cuban, Mexican, I	Puerto Rican, etc.)	White, etc.	
after on ul", o	by F	3 Widowed 4 Divorced If Yes, Give Yeer 197	1-73		No specify:			HITE
1215-0036 doe filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	Da L	15. Decedent's Education (Specify only highest grade comp	du	cedent's Usual Or			16b. Kind of Busines	s/Industry
6 n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		C T T T T		CONCED	CI CITI ON
5-003 led withi tygiene. other th	Ē	1 2		TILE	SETTER 18 Mother's	Name (First, Middle, M	CONSTR aiden Surname)	OCTION
filed tribe	Be C					,	GLARSKI	
	O B	GEORGE HAMMEN 19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address		er or Rural Route Num		ate, Zip Code)
MD d 2 should be and 37 is numberic	-1	TOM HAMMEN/ BROTHER	60	5 HARBO	UR OAK	DRIVE, ED	GEWOOD, M	D 21040
G, M 1 and 2 Health item 2	ŀ	20a. Method of Disposition		Disposition (Name y or other place)	of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If item 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Removal from State	3		ATORY	1/28/2011	BALTIMO	RE, MARYLAND
nit. P artme ortar	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	I Dill VI.			LER INC.		
in in Dep	- 1	The state of the s	1	1 700 S	. CONKI	LING STRE	ET,BALTO	.,MD 21224
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not e	enter the mode of	dying, such as ca	rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disease a. Contact Gunshot	Wound of H	ead				Death
ZAAIIIIIEI	- 1	or condition resulting in death) Due to (or as a consequence)	uence of):					
	<u>,</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq	uence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
i e 1.	Xar	events resulting in death) Last Due to (or as a conseq	uence of):					
rand ransit		d						
6 be ex e be ex ysician burial	Medical	UNPENDED AMENDED					2024 Date of dollar	2001
3760, ficate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	of pregnancy 2	Fetal death	3 Ectopic	pregnancy	23d. Date of deliv Month	Day Year
Box 687 death certific the attending p	<u>S</u>	past 12 months?		Other (Specif				
BO) e deatl the att	Physician	1 Yes 2 No 9 Unknown 9 Unknown						t death 2
that the detache	by P	Part II. Other significant conditions contributing to death	but not resulting i	n the underlying o	ause given in Par			to the cause of death?
S, P irres tl	象							autopsy findings available
ords, w requir s been s should	Completed					24a. Was a autop	sy prior t	o completion of cause of
(ecc	E					perfor		
tal Reccion: The law	BeC	25. Was case referred to medical		26	Place of Death (
Vita hysici this o	TO B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatien		patient 3 DC		Nursing Home 5		her: Scene
1 of Jing Ph. After the funeral		27. Manner of Death 28a. Date of Injury Natural 5 Paneling FOUND:	/ 28b. Til	′ ′	sc. Injury at Work?	Subject shot	ow injury occurred self	
ivision or Attend after death. Director:	äti	2 Accident Investigation Jan 24, 2011	0930 1	hrs	1 Yes 2 🗸		Page 1 and Number of	Rural Route Number, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the sa fler death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:	3 V Suicide 6 Could not be determined (Specify) rough	-	n, street, ractory, o	office building, etc		tate) ard Street, Baltimo	
Di ospital hours a meral I		4 Homicide			in a state and also	100		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	<u>sa</u>	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam	knowledge, deati ination and/or inv	n occurred at the t restigation, in my o	opinion, death occ	curred at the time, date	and place, and due to	the cause(s)
To t To t	Medical	and manner stated. 29b. Signature and title of certifier			License number		29d. Date signed (i	
	= 5	had and mo			O.C.M.E.		January 25, 20)11
1		30. Name and address of person who completed cause of de	ath (Item 23a)					
100		Ling Li, MD Assistant Medical Examiner		Itimore Street	, Baltimore, N	ND 21223		
S	tate		s Signature		-			
Regis			park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mary		artment of F <i>tificate of L</i>			lene leg. No.	01000		
	Physicia	n/	1. Decedent's Name (First, Middle, La					2. Date of Deat	No. of	3. Time of Death 7:05 PM M		
	Medic Examin	al	Mildred M. Huds 4a. Facility Name (if not institution, giv			4b. City, Town, or	Location of Death	Januar y	4c. County of Death			
	<i>)</i>		Stella Maris			Timoni If Under 1 Year	um If Under 24 Hrs.	I a a a a a a a a	Baltimo			
	Funeral Director		5. Social Security Number 219–12–8034	Sex 7. Age (In §	yrs. last birthday) 7 Yrs.	Months Days	Hours Min.	8. Date of Birth J <i>(Month, D</i> ay; January	7'ear/1924 N	rthplace (State or Foreign aryland		
	Maryland Ba-f show tified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		c. City, Town or Loc	cation Timonium		-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	ith the l	ral Di	10e. Street and Number Stella Maris 2300	Dulaney Valley	Road	10f. Zip Code	093		g. Citizen of What Country? USA			
0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In page 1 and 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ģ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			Specify.	te, etc. White				
:05 P.M. Maryland 21215-0036	within 72 ho giene. er than "na , the Medic	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) Unknown		(Give F	lent's Usual Occup. kind of work done of O NOT use retired) Ice Worker	ation furing most of work	ing	16b. Kind of Busines: Griffe Clothing Fa	en Brothers		
P.M.	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Louis Rexroth				18. Mother's Nam Mari e	ne (First, Middle, N e Rosier	Maiden Surname)			
:05 F	d 2 should alth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Warren L. Hudson	Type, Print) Son	19b. Mailin	ng Address (Street a V411 Sampso	and Number or Rur n Road, Pai	r Rural Route Number, City or Town, State, Zip Code) Parkton, Maryland 21120				
7 Baltimore.	Page 1 an ment of He tant: If iten lury or othe	v 8	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🖟 4 🗆 Donation 5 🗀 Other (Spec	Removal from State	Ob. Place of Dispo cemetery, crem Lake View	natory or other plac	e) 1/28,	Date /2011	20c. Location - City of Sykesville,			
Balt	permit. Depart Import any inj		21. Signature of uneral Service Lice	Henss) 18% 3%	ıPgeerdenss 531 Falls R	Seffizy Functional, Baltir	eral Home, nore, Mary	Inc. 21211 land	ļ		
RY 23, 2011	s e,	edical Examiner	23a. Part 1. Exper the disease, or conshock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death) Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	or the mode of dyin	g, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death			
JANUA Box 68	e death certiff the attending hed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	y		23d. Date of d Month	elivery Day Year		
S. P.O.	vires that the signed by	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	oacco use contribute	o the cause of death?		
MILTRED HUDSON Division of Vital Records. P.O.	The law requate has been bage 2 shou	Completed						24a. Was ar autops perform 1 Yes	sy prior to	utopsy findings available completion of cause of es 2 2 No		
HUI Ital I	ician: 1 certifica rector, p	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital:		_ Othe	ace of Death (Chec	k only one)				
MILI RED	rcing Phys ttt . ' fter this - uneral di	cate: To	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	2 ER/Outpatien 28b. Time of injury	28c. Injury	4 Nursing H		ence 6 Othe <u>r (Spe</u> ow injury occurred	cify)		
MII Divisio	tal or Atter rs after dez al Director ed in by th	Il Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 280 Place of Injuny		eet, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,		
	To the Hospital or Attending Physician: The la within 24 ours after death. To the Funeral Director: After this certificate ha complete filled in by the uneral director, page	Medical	(Check 2 Medical Exar	ysician: To the best of my kininer: On the basis of exami	nation and/or invest	tigation, in my opinio	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.		
•	To with cor		29b. Signature and title of certifier		of HM	D 29c License	$\frac{1}{2}$ 7 (10 2	29d. Date signed (Mon	tn, Day, Year)		
	LV		30. Name and address of person who ERNESTINE WRIC		(Illem 23a) (Type, P 3 <i>00 DULAN</i>		Y ROAD T	TIMONIUM	, MD 21093) /		
	Sta Registra		31. Date filed (Month, Day, Year) JAN 28		Signature .	harles						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 12:13A M Helen B. Heim January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth May 22, 1925 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours 1 □ M 2 🗓 F Baltimore Director 212-22-7607 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Baltimore Lutherville Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral USA 8417 Thornton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3
Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance <u>Administrator</u> other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Helen Hoover John E. Beatty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8417 Thornton Road, Lutherville, Maryland George H. Heim/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/26/2011 Glen Burnie, Maryland Atlantic Crematory Fungral Service Lightse: Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Interit e disease, or complica ons that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one vause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HOAK PALLOKE Physician/ disease or condition Medical resulting in death) Examiner CHRONIC OBSTRUCTIVE LUNG DISETAGE Sequentially list conditions, if any, leading to immediate cause. Et et underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, P. Completed by PAROXYSMAL ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown EXPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 autopsy PERPHERAL ARTERIAL DISEASE To the Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 WNo ဥ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Lecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Anha Nteroleouse: DO8896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEAIR, MO 21014 FULFORD HIS Tropon Doublem Registrar's Signatu Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23 2011 6:05 A M January Katherine Μ. Hubley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months oct 23, 1929 New Jersey Director 151-20-7553 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sh notified a 1 ☐ Yes 2√ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral 20877 United States 301 Russell Avenue Apt 331 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ပ Katherine Taylor William Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8103 Glenmore Spring Road Bethesda, Maryland 20817 David A. Hubley/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD R. Thomas antta M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSI Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TRACT Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 oerforme certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1- Inpatient 2 ER/Outpatient 3 DOA 28c, Injury at work? 1 ☐ Yes 2 ☐ No . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 24 hours after deatl Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check only one) 29b. Signature and title of certifier 1123/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Molecula Drive Bao MO 3+e 2 10110 Iruona

DHMH 17 Rev 7/2009

State Registrar

5090

1107

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ bres 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie Battimore Washington Hospital Center 8. Date of Birth (Month, Day, Year) Jun 23, 1946 Birthplace (State or Foreign Country)
 Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 1 □ M 2 🙀 F Director 217-50-9844 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 any injury or other traumatic event, the Medical Examiner must be 1 Funeral 21060 U.S.A 7636 Spencer Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc ģ 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 ☐ XNo Specify Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Private Company Elementary/Seconday (0-12) Food Manager Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Harris Andrew Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8008 Pine Ridge Road Pasadena, Maryland 21122 Tia Pinkard Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Glen Burnie, Md. 01/26/1 4 Donation 5 Other (Specify) Glen Haven Memorial Park 22. Name and Address of Facility 21. Signature | Funeral Service Licens Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 01 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securitally list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran-Hospital or Attending Physician: The law requires that the death certificate be execut that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed 1 ☐ Yes 2 No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Mann of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifu 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23) o filed (Month, Day, Year) JAN 28 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ameilia 2011 11:55PM Hart Gloria Januarv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 924 Amer Drive Fort Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) North Carolina **Funeral** 1 □ M 2 🗶 F Hours Min. NOV . 26 Director 237-25-4732 54 1956 Usual Residence of Decedent · 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ¥ Yes 2 □ No Fort Washington MD Prince Georges 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a or Funeral with 20744 USA 924 Amer Drive items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc þ 1 X Never Married 2 Married ö 1 Yes within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled NOne other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lewis Hart Martha Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant; If item 27 is 20744 Fort Washington, MD Curtis L. Hart/Brother Amer Drive, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Northeastern Cem. 1/31/11 Rocky Mount, NC 22. Name and Address of Facility AGEE/MCKINNON Funeral Service 21. Signature of Funeral Service Licenses M00969 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions cause (Disease or iinjury Unio to (or as a nonsequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death Other (specify) Yes 2 X No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: 1 🗌 Yes 2 **X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the boot of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the ba s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated r: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Certifying Nurse Praction erson who completed cause of death_(Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:01 PM 2011 <u>Beatrice Irene Jefferson</u> lanuar 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6 HOSPITE Baltimore N/A | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trigonomy | Trig 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Delaware Director 221-10-5211 89 Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Examination up to notified at Director 1 Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 5741 Edmondson Ave. 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: Black ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Baltimore City 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools years School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Harvey ပ Edward Knotts Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leland Jefferson(son) 2811 Green Lawn Rd., Baltimore, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Nat'L Cem. 4 ☐ Donation 5 ☐ Other (Specify) 01/31/11 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PA 21217 Joseph H. Brown Jr. Funeral Home P 2140 N. Fulton Ave., Baltimore, MD relians 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐No Ö 9 Unknown 9 Unknown ď. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ficate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No certificate 2 ₽No Vital 1 ☐ Yes After this certification, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No iours after death. neral Director; A y filled in by the fi investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Medical 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD de prope 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD, 21229 900 Caton Debebe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

A. Markis
ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 12:30 PM Elfriede Johnson 201 Waltraut Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** INASHINGTON MEDICAL CENTE ANNE BALTIMORE GLEN BURNIE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 05-30-1921 1 □ M 2 😿 F Germany 89 Director 214-46-2284 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Anne Arundel Co. Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 United States 7220 Judy Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. id Mental Hygiene. marked other than "natural", or i þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 🕅 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Liquor 4 yrs. Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Ehlert Eliese** Max Last 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD Mr. James E. Schwabline /Friend 7222 Judy Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem Garden's 1/29/2011 | Marriottsville, MD 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation Service PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Kenal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 F FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CROHNS Division of Vital Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 N death? To the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No 1 DFInpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Matural Natural 5 Pending 2 \square No Investigation Acciden
Sulcide Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signatylre, and title of certifier 29d. Date signed (Month, Day, Year) D0061219

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OHNSON

Registrar

BWMC

HOSPITAL GLENBURNIE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVINDER S 31. Date filed (Month, Day, Year)

JAN 28 201

SINGH ARORA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Isis MacKenzie Jordan 200 PM Sarum Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Baltimore Baltimon Spital 5. Social Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 🕇 Director N/A MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Woodlawn 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5517 Clifton Avenue 21207 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) other than College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha **Infant** None Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marque A. Jordan Isis K. Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isis K. Wilkins (Mother) 5517 Clifton Avenue, Woodlawn, Maryland 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 C Other (Specify) 01/27/2011 Bayview Crematory Baltimore, Maryland Signature of Funeral Service Lipensee Hubbard Funeral Home, Inc. Avenue, Baltimore, Maryland 21229 4107 Wilkens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No page 2 🗌 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 🗶 No မြ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of 28d. Describe how injury occurred M Natural iniury 5 Pending , **o**r, ,/s after dea, ,.**eral Director:** A^g >-d filled in by the Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saral 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 120000 AYDEN JANU P924 20 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c, County of Death **Examiner** NVERSITY OF MARYLAND
Social Security Number 6. Sex BALTIMORE MEDICAL If Under 1 Year Age (In yrs last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Hours **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Fayette 2300 W. 21223 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married þ ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) and Mental ပ meira McCullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samera McCullough 2300 and 2 s Health a 2/223 MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1. Burial 2 Cremation 3 Removal from State Manonal Randallstown, MO 4 Donation 5 Other (Specify) 21. Signature of uneral Service/Licen 23a. Part J. Effecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ CARDIDRESPIRATORY 4A1 WRE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner THRUMBOEMBULSA NDOCARDITIS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) physician the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PREMATURITY Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an TIS SIP DEJUNDSTOMY cate has autopsy HEMORRHAG 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? injury Natural 5 Pending 2 🗌 No ☐ Accident Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Funeral Direct completed filled in by 4 Homicide determined City or Town, State) hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALISON SOUTH ST BAUTINORE GREENE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 28

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2. State Registrar	s State oile Maryland	01 9287 Cen	izorenini H tificate of D	lealth and Death		giene Reg. No. 20	1 9 8 18
	Physic /Medi	cal	Decedent's Name (First, Middle, Last A. Facility Name (If not institution, give		Key	medi	Legation of Da	2. Date of Dea	Day 2	Year 20.48 M
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	Funeral Director		5. Social Security Number 6. Se 216-68-6950		t <i>birthd</i> ay) Yrs.			n. (Month, Day	h, Year) 5-1954	Birthplace (State or Foreign Country) M D
	land low		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	h the Maryland or 28a-f show notified at	Director	MD n	a Bal	timor	٠.				¹x Yes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip-Code			10g. Citizen of Wh	nat Country?
	leath w	Funeral	427 E. Preston	Street 12. Was Decedent Ever in U.S.	13 14	2120		(Chooify Van as No	USA	And the lates
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes No If Yes, Give Year or Dates:		Yes, specify Cubar	Specify:	(Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. Black
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Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me	2	Willie Kennedy					Lee Ba	- 11 - 0 - 0	
Mar	is an		19a. Informant's Name/Relationship (Ty)					Rural Route Numbe		
	f Healt fem 2		Sharon Kennedy 20a. Method of Disposition	20b. Plac	T8 N ce of Dispos	 Divis ition (Name of 	ion St	reet Sa	lisbury	y, MD 21801 ity or Town, State
E O	e = ÷ >		1 Burial 2 □ Cremation 3 □ R Donation 5 □ Other (Specify)	cilioval ilotti State I	, ,	cemete	7	i i	Lansdow	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.	İ	21. Signature of Funeral Service License		22.	Name and Address	s of Facility	March E	ast F/E	I III
	<u> </u>	-	23a. Part 1. Enter the disease, or compli	carons that caused the death				Avenue		
	Physician		Immediate Cause (Final	cause on each line.	50		g, such as cardi	ac or respiratory an	rest,	Approximate Interval Between Onset and Death
)	/Medical		disease or condition resulting in death)	Due to (or a a consequen	nce of):	/				
	Examiner	-	Sequentially list conditions,				\sim			
	ansit	盲	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events	Due to (or as a consequer	ice oi):		() 1	A CENTY MEDICAL EX	AMINER	
ó	an anc		resulting in death) Last	Due to (or as a consequen	ice of):	CERT	FICATION APPR	NEBRY MEDICAL EX		
8760,	cate be executed physician and sthe burial-transit	edical	d	-						
Box 6	death certific	M/us	IF FEMALE; 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date of	of delivery
). B(The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			Month	,
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of Vital Records,	v requires the							1 □ Ye	s 2 No 3	☐ Probably 4 ☐ Unknown
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			25. Was case referred to medical	_					ned?	ath? Yes 2 No
f Vii	ysic s ce dire	To Be	examiner?	ospital:	Outpatient	3 □ DOA Other:		ath <i>(Check only one</i> Home 5 \square Reside		(Specify)
0 0	ding Phy h. After this funeral		27. Manner of Death 1		b. Time of Injury	28c. Injury a Work?	at		w injury occurred	Ореспу
Division	5 ± W	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home.	farm etroet		s 2 No	204 Location (C4	and an el Alicerta	0 10 1 11
á	P # # P =	Certification;	4 Homicide determined	building, etc. (Specify)	i larrii, airoo	, ractory, office		City or Town,		or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier, (check only one) 1 ✓ ertifying Physi 2 ☐ Medical Examin	cian: To the best of my knowled er: On the basis of examination and manner stated.	lge, death o and/or inves	ccurred at the time stigation, in my opin	, date and plac nion, death occ	e, and due to the ca curred at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
	ro the within to the comple		29b. Signature and title of certifier	and marrier stated.		29c. License n			d. Date signed (A	
			12/2	MI		1K23-	-000	5	nnn	RIJ 1.2011
7		3	0. Name and address of person who co	ted cause of death (Item 23	la) (Type, Pr	int)	000	Manus Manus		71.12
	Stat	e 3	An Mony 11. Date filed (Month, Day, Year) JAN 28 2011	32 Registrar's Signature	1	1	600	North Wolf	re St, Balti	more, MD, 21287
	Registra	ır	JAN 28 2011	32. Registrar's Signature	parke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gertrude Kennedy :55 P M Medical 2011 January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Quail Run Assisted Living Parkville Baltimore Co. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth
(Month, Day, Year)
Aug. 23,1927 9. Birthplace (State or Foreign 1 □ M 2 😾 F Days Months Hours Min. Director 16-20-5250 Aug. Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 K No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 758 Fulbrook Road 21222 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black White etc. Yes 21 No If Yes, Give Year or Dates 1 Yes 2X No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Prechtel Edna M. Hubbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Kennedy (Daughter) 758 Fulbrook Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem. Gardens 1/28/2011 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOVASWIAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events led by the attending physician and detached for use as the burial-trans resulting in death) Last DEMENTIA Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day g 🗌 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy this certificate performe death? Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

eath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 322 A M 2011 Mary Elizabeth Karpovich 25 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital N/A Aques times If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jun. 16, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕅 F Months Days New Jersey 212-24-9547 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events any injury or other traumatic events any injury or other traumatic events and any injury or other traumatic events any injury or other traumatic events and any injury or other events and any injury or other events and any injury or other events and any injury or other events and any injury or other events and any injury or other events and any injury or other events and any injury or other events and any injury or other events an 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 ☐ Yes 2X No Arbutus Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 5030 Arbutus Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Young George Brown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5030 Arbutus Ave., Arbutus, MD 21227 Vita Donna Simmonds - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery; crematory or other place) Date XBunial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
Signature of Fundral Service Licely Loudon Park Cemetery 1-28-2011 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dueinucinia /Medical Due to (or as a consequence of): Examiner congrestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed ren attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 sh 2 1 No 1 □ Yes 2 400 1 Tyes r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.0 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 ☑ Natural 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO Jan 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore manyland Tao 900 Avenue Caton INVI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 2011 fares Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Mary

Karpovich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ź6, January Lorraine Kenner 2011 5:27P [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1504 Severn Road Severn Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2🛣 F Months Days Hours Min. Oct. 12, 1929 81 217-26-4630 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Severn 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1504 Severn Road 21144 U.S.A. "natural", or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛛 No Black, White, etc. 1 Never Married 2 X Married Ę Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Contract Clerk Westinghouse 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 2 Naomi Clare George Metzler, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1504 Severn Road Severn, MD Mr. Irvin Kenner / Husband Date 2 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2011 Glen Burnie, MD any injury Signature of Funeral Service Licensee 22. Name and Address of Facility 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 2106 10 disease or condition - Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding in death). Due to (or as a consequence of): Examin and -transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 plonths?

1 Yes 2 No Day ed by the a detached f 1 ☐ Yes 2 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ or Attending Physician: The law requires Records, 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 2 🗆 No 1 Yes 25. Was case referred to medical of Vital director, 26. Place of Death (Check only one, Be examiner? Other: 2 No 1 Yes ပ္ 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1X Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature Year) State 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, 201^{Tear} 5:35A Virginia Perrin Knowles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Life Care Mitchellville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Month, Day, Year) an 10, 1924 Months Days Hours Min. 578-22-2251 **Director** Washington, DC 87 Jan Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No Mitchellville Prince George's Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20721 United States 10450 Lottsford Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural" Specify: Completed 3 Widowed 4 Provoced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Religious Organization 5+ Minister other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental F tant: If item 27 is marked of ဂ္ Bernard Perrin Virginia (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2736 Rittenhouse St, NW Washington, DC 20015 Mary S. Pence/executor 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State ö 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Final Journey Crematory 1/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign Fre of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) years Senescence Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending XNatural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined

State Registrar

24 hours Funeral

within 2, To the F complet

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, 1

Cynthia M Milliams, DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O. 3720 Upton Street, NW

32 Registrar's Signat

✓ DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H0058032

29d. Date signed (Month, Day, Year,

Washington, DC 20016

January 25, 2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Gordon Kummell Jan 21, 2011 5:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville **Baltimore** Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Min. Director 577-14-1036 91 Nov 19, 1919 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director **Baltimore** MD Catonsville 1 🗆 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6605 Altamont Ave 21228 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 M Married 3/1/1943 ģ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 2/1/1946 Year or Dates and Mental Hygiene.
is marked other than "natur raumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist **Trains** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick August Kummell, Sr. Katherine Leslie Wrenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A Kummell 6605 Altamont Ave Catonsville, MD 21228 Health permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Jan 28, 2011 Baltimore, Maryland **Loudon Park** 4 Donation 5 Donation 5 Dother (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A Simatrire of Funeral S ice Liu Inse 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) arkinsons Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) 9 Unknown be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension 1 Yes 2 No 3 Probably 4 Hinknown Completed should erescosancolar Locident 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2)corau tra this certificate Yes 2 N 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 2 🖪 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Narsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D1966 01-21-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +508 Glen Borns, Marylan Hu ways as 310

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Dav Year Physician/ HENDERSON KLINE 1126 NORALI 2011 TAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard **Howard County General Hospital** 8. Date of Birth (Month, Day, Year) Oct 16, 1933 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months 219-30-5841 Yrs Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4806 Knoll Glen Dr. 21043 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? 3/25/1953 Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3/24/1955 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "! life. DO NOT use retired) Elementary/Seconday (0-12) Sales Sales Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) John Louis Kline Sr. Alice Gonder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health ar Important: If item 27 is spouse Margie Kline 4806 Knoll Glen Dr. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan 28, 2011 Garrison Forest, MD Maryland Veterans Cemetery 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ MYOCARDIAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or iinjury that initiated events requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 1 No page Hospital or Attending Physician: The certificate 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2, No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1- Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Fleming Atha

005/05/

10632 Little Patuxent Pwky Ste 406 Columbia, Md 21044

11-00643	
Antonio Lee	

-00643		Please Type or Print in Black Indelibl			e. 1 1 1 1 1 2 2 2
tonio Lee		State of Maryland / Departmen 1- For State Certificate Registrar	t of Health and Mental F of Death	Reg. No	
Physici edical Exam		1. Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal	2. Date of Death Month Day January 23, 20	
1		Johns Hopkins Hospital	Baltimore		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 213-06-8975 1 M 2 F 35	y) If Under 1 Year If Under 24Hi Months Days Hours Mi	_ , ,	975 Sountry) 9. Birthplace (State or Country)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
and f show	ō	MD Balt	imore		1 X Yes 2 No
Maryl r 28a-1	Director	10e. Street and Number	10f. Zip Code 21216	10g. Ci	itizen of What Country?
with the s 23a c		11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (§	Specify Yes or No-	USA 14. Race - American Indian, Black,
fter death ' ', or item	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puert Yes 2 No specify:	to Rican, etc.)	White, etc. Specify: Black
iours al satural	ed by	durii	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re		Kind of Business/Industry
5-0036 led within 72 h Hygiene. tother than "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	oar Owner	S	elf Employed
Fe, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland Metalth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at once.	Be	12 Eather's Name (First, Middle, Last) Wight L. Lee	B	ne (First, Middle, Maider	Dowtin
MD 2 d 2 shoul th and M n 27 is m	၉.	19a. Informant's Name/Relationship (Type, Print) 19b. M 18c	ailing Address (Street and Number or	St. Bal-	City or Town, State, Zip Code)
re, M l and 2 Health if fiten 2 er traum		20a. Method of Disposition 20b, Place of Di	sposition (Name of cemetery, or other place)	Date 20c.	Location - City or Town, State
Page lent unt:		4 Donation 5 Other Specify:	iwn Cometery 1-	29-11 N	loodlawn, MD
Baltimo permit. Pag Department Important: injury or of		21. Signature of Roneral Service Licensee	22. Med early Address of Codinic Co	elne tune	ral Services
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest, sh	
/Medical £xaminer		Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
,		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	iner	if any, leading to immediate cause. Enter Underlying Cause			
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execut an and al - tra	g	UNPENDED AMENDED			
760, icate be physic the burn	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			3d. Date of delivery
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit	ician	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	nancy	Month Day Year
D. BO: t the deatl by the att	Physician/Medi	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco	use contribute to the cause of death?
ires that the signed by be detach	ρ			1 Yes 2	✓ No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law require After this certificate has been signed in ector, page 2 should b	Completed			24a, Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Reco The law icate has	E			performed?	
ftal Rec sician: The s certificate irector, page	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpa	26.Place of Death (Check		ence 6 Other:
n of V ding Phy. After thi funeral d	일	27. Manner of Death 28a. Date of Injury 28b. Time	e of Injury 28c. Injury at Work?	28d. Describe how inj Subject shot	
Division tal or Attendiins after death.	atio	1 Natural 5 Pending Jan 23, 2011 2241 hrs	1 163 2 110	<u> </u>	
Divis pital or At ours after d ieral Direct	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, (Specify) Local Street	street, factory, office building, etc.	or Town, State)	and Number or Rural Route Number, City ument Street, Baltimore,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Rooeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the control one one of the control			
To To com	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Jan	nuary 24, 2011
1-14		Carol Allan, MD Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, M	1D 21223	

State 31. Date filed/Month, Day Year).
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ratiicia Aiiii Laiio	L	1- For State Certificate of Death	F	Reg. No.	11021
Physiciar Medical Examina		1. Decedent's Name (First, Middle,Last) Patricia Ann Lanocha	2. Date of Dea Month January 2	Day Year	3. Time of Death 1425 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I 3011 Hiss Avenue Parkville		4c. County of Deal Baltimore Co	
Funeral Director		5. Social Security Number 220-52-4337 6. Sex 1. Months 2X F 63 Yrs. 63 Yrs. 63 Hours		irth(MM/DD/YYYY) 9. Bi 12 13,1948 Forei	
iow any		Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 No
he Maryland or 28a-f show	Director	10e. Street and Number 10f. Zip Code 21234		10g. Citizen of What Col United Sta	
s after death with rral", or items 23.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, P 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us	uerto Rican, etc.)	White, etc. Specify: 16b. Kind of Business	
-0036 I within 72 I giene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Payroll	Name (First, Middle,	John Hopk Universi	ty
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		John F. Baclawski Milo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	red M. Ju	mber, City or Town, State	
e, MD I and 2 sho Health and item 27 is	-	Lisa Karin Conrad (Daughter) 17 West High Street Na 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	Pennsylvania 1 [*] 20c. Location - City o	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Exams Funeral Chap	January 28, 2011	Dundalk, Mar	_
M ងក់ អី គឺ Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	i Parkville	. Maryland 212	Approximate Interval
/Medical Examiner		failure. List prily one dause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of Liver Due to (or as a consequence of):			Between Onset and Death
, ,	Yalling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or figury that indicate events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED 23a,27 per me g913 3-16-11 23c. If yes, outcome of pregnancy			
e executed cian and rial - transi	- E	d □ AMENDED 23a,27 per me g913 3-16-11	vt		
cath certifications as a strenging for use as	y sicially mid	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	regnancy	23d. Date of deliver Month	y Day Year
P.O. E es that the d igned by the detached	3	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		obacco use contribute to	
Division of Vital Records, P.O. hal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	andino	20 Plant of Dark (O	1 Yes	osy prior to open death?	utopsy findings available completion of cause of es 2 No
ician:	Ď	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 N		Residence 6 ✔ Othe	r: Scene
on of Vi ath. r: After this he funeral dir		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe	how injury occurred	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, S	Street and Number or Ru State)	ural Route Number, City
To the Host within 24 ho To the Func completely f		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	1	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo January 23, 201	
st vie of	1	 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Balti 	more, MD 2122	23	10000000
Stat Registra	e :	31. JANIET MONTO (Year) (32. Registrer's Signature)			

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ı	Physicia	in/	State Registrar 1. Decedent's Nam	nend It	e, Last)				Milea	te or l	3647R	3/201	2. Date of D Month	Reg. No eath		Year	3. Time (
	Medic Examin	cal	4a. Facility Name (if		, give street)	<u> </u>				of Death	JAN		c. County	of Death	111,5	
GOOD SAMARITAN HOSPITAL Funeral Director 5. Social Security Number 416-50-7545 6. Sex 7. Age (In yrs. last birthday) 71 Yrs. Hours Hours							Under 24 Hrs. 8. Date of Birth			9. Birthplace (State or Foreign Country) A1								
	yland -f show ed at	ctor	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town o									10d. Inside City L		City Limits	
	th the Mar 3a or 28a t be notifi	Funeral Director	MD na 10e. Street and Number 115 E. Melrose Aven				Baltimore 10f. Zip Code 21212						10g. Citizen of What C					es 2 🗆 No
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married				t Ever in U.S No	Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer					Specify Yes or No- 14, Race			- Americ	- American Indian, , White, etc. Black	
Maryland 21215-0036	hin 72 hours ne. than "natur ie Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 16b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)						st of worki	st of working				of Business Industry				
and 2	oe filed with ntal Hygiel ed other is event, the	To Be C	17. Father's Name (First, Middle, Last) 18. Mother								W. R. Grace Mer's Name (First, Middle, Maiden Surname) Cinda Lindsay							
Maryla	2 should be the and Me 27 is mark traumatic		19a. Informant's Name/Relationship (Type, Print) Alice McKinney-Wife 19b. Mailing Address (Street and Number or Rura 1030 E. 33rd Street								01010							
Baltimore,	age 1 and ent of Hea nt: If item or or other		20a. Method of Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Donation 5 Other (Specify) 20c. Location - City or Town, State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1-19-2011 Lutherville, MD										MD					
Baltii	permit. P Departm Importal any inju		21. Signature of Fu			In In	٠	2					rch Ea Avenue		F/H Balto	o,ME	212	02
	Physician/	8 3	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis/Pneumonia Sepsis/Pneumonia															
	Medical Examiner	L	resulting in death) Du-lo (or as a consequence of): Gangrene of Right Leg								t Leg	1 hys						
1078	cuted nd transit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	JTI	to (or as a consequence of): Peripheral Vascular Disease To (or as a consequence of):													
5 ME 68760	ath certificate be executed attending physician and for use as the burial-transit		The specific															
x f≥ 7. Box 68:	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 4	yes, outcom Live Birth Pregnant Unknowr	n 2 ☐ Feta at time of d	ldeath 3	Ectopic Other (s	pregnanc	У		Ĭ.		23d. Date Mon	e of delive		Year
+aIs, F.0	requires that the de been signed by the should be detached		Part II. Other signif	icant condition	_	ting to death	but not res	Hyper									ne cause of bably 412	
T+T Second	he law req tte has bee	Completed by	Rhobe Pulmon	lomy	/ _	~		Disease lermia	,Chr	onic	Obstr	utive	24a. Was auto perf 1 \(\sum \) Yes	opsy ormed? _	pi di	rior to co eath?	psy findings mpletion of 2 \(\square\) No	available cause of
Vital F	ysician: The law I is certificate has t director, page 2 s	To Be C	25. Was case referre examiner?		Hospita	al:		ER/Outpatie	nt 3 🗆 [Othe	ar.	ath (Check						
on of	ttending Physication of the control of the funeral dispersion of the f	Certificate: 7	27. Manner of Death 28a. Date of injury 28b. Tin					28b. Time o injury					28d. Describe how injury occurred					
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ		e. Place of Ir building, e	njury - At ho etc. (Specify)	me, farm, str)	eet, facto	ry, office			28f. Location (City or To	Street an wn, State	d Number)	r or Rural	Route Num	nber,
	the Hospi hin 24 hou the Funer npleted fil	Medical	(Check 2 only one) 3	Certifying Medical E Certifying	xaminer: On	the basis of	examination	and/or inves	tigation, ir death occ	my opinio urred at the	n, death on time, da	occurred at	the time, date	and place he cause(e, and due s) and mar	to the car ner as st	use(s) and mated.	nanner stated.
	o vit		29b. Signature and t	title of certifier						c. License)				(Month, 1	Day, Year)	011
	(C)		30. Name and address AMT B 31. Date filed (Month	SANSA	vho complet	D !	5601	LOCH		EN B	LVD	J B	ALTIM	40R	E,	M.	D 212	239
100 miles	Stat Registra			JAN 28	2011	32. begist	trar's Signat		arka	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MCCLOUD URANE Physician/ 3:53 1 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SECOURS HOSPITAL BALTIMORE n/a 5. Social Security Numbeunk If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) VA 1 🗆 M 2 😾 Hours Months Days 1270971945 65 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 North Mount Street #104 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 2 1 Never Married 2 XMarried Maryland 21215-0036 within 72 hours after nit. Page 1 and 2 should be filed within 72 hours afti artment of Health and Mental Hygiene. Internet If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify: If Yes Give Specify. 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Educational System Clerical Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Williams Nancy Pearl Brown permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carnell Colvin-Son 229 N. Mount St #104 Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1.31.2011 Baltimore, MD nature of Funeral Service Licensee John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD any Art 1. Enter the disease, or complications that caused the dijath. Do not enter the mode of dying, such as cardiac or resultatory arrest, shock, or heart failure. List only one could be a public of the country arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and tran resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Year Yes 2 Wo g Unknown 0.0 Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the sign of the sign Part II 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas page 2 autopsy performe death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to 26. Place of Death (Check only one) Be examiner? Other: 2 110 မ Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 2011 morso

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 201 T Leslie Morton Nei1 5:08 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Sep. 28, 1969 Birthplace (State or Foreign Country)
 TA **Funeral** 1 🖾 M 2 🗆 F Days Hours 225-41-6675 41 **Director** Usual Residence of Decedent show 10a. State with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No VA Culpeper Jeffersonton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5367 Scottsville Road USA 22724 items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Force 1 X Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. þ 5-0036 within 72 hours after 1 ☐ Yes 2 🛣 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 10 Laborer Building Construction Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Leslie Louwelldon Morton Bertha Elizabeth Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha E. Morton/Mother 5367 Scottsville Road, Jeffersonton, VA 22724 Baltimore, Important: If item 20b. Place of Disposition (Name of Pine Grove Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date Separtment of ö 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 1-28-2011 Jeffersonton, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joynes Funeral Home, Inc. len PO Box 3633, Warrenton, VA 23a. Parr . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final myocardial intarction Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner menths hypertension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to kr as a consequence of) Cause (Disease or linlury signed by the attending physician and dbe detached for use as the burial-trans that initiated events the Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕦 Unknown 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 2 No Other: 1 Inpatient 2 FER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062839 20, 2011 30. Name and address of o completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Manyland 20850 MD Jenniter 31. Date filed (Month, Day, Year) State Registrar

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MORTON

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lo1a Yvonne Marchini 201112:40 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Timonium <u>Stella Maris Hospice Center</u> 8. Date of Birth (Month, Day, Year) Feb. 15,1928 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🙀 F Hours Kentucky 82 Director 219-20-6778 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 3108 Parktowne Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Martin Marietta 12 Years Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leona Hill Cecil Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Celtis Court Fork Mary 1 and 21 051 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is (Daughter) Ms. Jan Gay Fork, Maryland 21051 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/26/2011 Lakeview Cemetery Sykesville, MD 21. Sature of Funeral Service Licensee 22. Name and Address of Facility any Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 7922 Wise Ave. a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ END STAGE DEMENTIA Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: မ 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\subseteq \text{Yes} \) 1 X Natural 5 Pending 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical within 24 hou

To the Fune

completed file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title signed (Month, Day, Year) 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD CRNP TIMONIUM, MD 21093

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

8

a.m.

12:40

JANUARY

LOLA MARCHINI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Year :03AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 24 Hrs If Unde Funeral 8. Date of Birth 1 □ M 2 🖔 F Months Min 7-21-1952 Year) 216-58-2992 58 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Directo 1 ☐ Yes 2 🕅 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 8910 Maplebrook Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Completed by 1 Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: African-American 3 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elmer Burnett Maggie Lisdey 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8910 Maplebrook Road, Randallstown, MD 21133 Clarence McBride/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State 1-28-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Randallstown, MD 21133 Liberty Road Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician/ Atherosclevoti disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Exam rials to or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death n signed by the a ld be detached f 9 Unknown a 🗆 Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe certificate 2 🗌 No 1 🗌 Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H6055644 24,2011 January s of person who completed cause of death (Item 23a) (Type, Print) 5461 ad Course A. Yorke 31. Date filed (Month, Day, Year)

JAN 28 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Luisa Musiani 1:00 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carrol1 Carroll Lutheran Village Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 16 1918 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🗓 F Hours Director 213-46-2970 92 <u>Italy</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Carrol1 Marriottsville 10e. Street and Number 10g. Citizen of What Country? Funeral 21104 1716 Amberly Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Completed White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 nath and Mental Hygiene.
a 27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Seamstress</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bianco Nuncia Guaglone Francisco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1716 Amberly Court, Marriottsville, MD 21104 Bert Musiani Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 1/29/2011 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Kovesken MO/314 PO Box 195 Svkesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician Due to (o s a consequence of): Proumenu Mense M Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Month Pregnant at time of death Yes 20 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident completed filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier xamination and/ 3 Certifying Nurse Fractioner: To within 2 only one) e best of my kny death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37940 m 23a) (Type, Print) 30. Name and address of person w 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert James Munn J<u>anuary</u> 2011 Р Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>5395 Mad River Lane</u> Columbia Howard 8. Date of Birth (Month, Day, Yea Jan 31, 1 **Funeral** Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days England Hours 1**℃** M 2 □ F 219-46-6378 Director 73 1937 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5395 Mad River Lane 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ <u>Professor of Chemistry</u> University of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Munn Irene Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Munn/wife 5395 Mad River Lane Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Hinal Journey Crematory 1/31/2011 Woodbine, Maryland 21. Signatule of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Himon M00957 stirin 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ METHSTATIC NEUROENDO CRINE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Pregnant at time of death Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Ka Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) JANUARY 27. 1 064931

★ DHMH 17 Rev 7/2009

State

Registrar

600 NORTH LIDER SMEET

32. Registrar's Signature

BALTIMORS

21287

NS

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID COSGROVE

28 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month **Hilda Mae Manyweathers** 0609AM Tancaru Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinal Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mir Year) 1 🗆 M 2 🙀 F Yrs Director 218-44-1872 Maryland May 22, 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗷 Yes 2 🗆 No **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with items 23a Funeral 2830 Virginia Avenue 21215 U.S.A death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Force Black, White, etc. 9 1 Never Married 2 Married "natural", or Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic avent the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence Townes Oliver Townes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2830 Virginia Avenue Baltimore, Maryland 21215 Admiral Manyweathers Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 Donation 5 Other (Specify) 01/24/11 Baltimore, Md. Loudon Park Cemetery 21. Signature of Fundal Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 Eutaw Place Baltimore, Md 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final O set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami sician and burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 2 No this certificate Yes 2 X No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) Hospital ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After iniury 1 🕅 Natural 5 Pending death. Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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Manyweathers

MD

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Graham I 31. Date filed (Month, Day, Year) JAN 28 2011 RES- DOE

January 17 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3:40 AM JANUARY 2011 HARRY MILTON MARKS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/ABALTIMORE 2600 GIBBONS AVENUE 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. Country) 1 🛛 M 2 🗆 F 0110571947 NY 066-38-6166 64 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State hours after death with the Maryland Director 1X Yes 2 ☐ No BALTIMORE MD N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 "natural", or items 23a or Funeral 21214 USA 2600 GIBBONS AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🕅 No Specify: Baltimore, Maryland 21215-0036 WHITE 3 Widowed 4 X Divorced Completed Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) UNIVERSITY PROFESSOR and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file
Department of Health and Mental I
Important: If item 27 is marked o
any injury or other traumatic ever ဂ RAE WARSHAUER MARKOWITZ **ABRAHAM** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IRINA SPECTOR-MARKS/DAUGHTER 2600 GIBBONS AVENUE, BALTIMORE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State CARROLL CREMATION INC:01/26/2011 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final METASTATIC PROSTATE CAUCKU Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Oue to for as a non-securing of it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and trar that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i 26. Place of Death (Check only one) 25 Was case referred to medical Be 2 X No 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) ပ္ 1 Tyes 28d. Describe how injury occurred 28b. Time of 28a. Date of injury 28c. Injury at 27. Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of use of death (Item 23a) (Type, Print) 1650 ONLEAUS ST 30. Name and address of person who completed c PIUSOH SUMBOHSUHOE s ENB ENG nD 12 021231-1000 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 01:37 P M Bhupindar Singh Nibber January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Hours March 19,1930 Director 80 217-06-1641 India Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Burtonsville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3617 Childress Terrace 20866 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married þ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Asian Indian "natural" Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) uld be filed within 7 1 Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed <u>Automotive Parts</u> marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shahbaz Singh Nibber Partap Kaur and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Lavleen Singh/Daughter 13809 Baywind Court, Silver Spring, Maryland 20905 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 X Cremation 3 Removal from State January 26, 4 Donation 5 Other (Specify) Odenton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will E Bau M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) a Streptococcal Bacteremia Medical Due to (or as a consequence of) Examiner Pneumonia <u>5 Days</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 physician Physician/Medical equires that the death certificate be Box 68760 the as attending IF FEMALE se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? jo Month Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Atrial Fibrillation 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should reen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 2X No 1 🗌 Yes 2 🗌 No Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ၉ 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending work' death. 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide filled in by the t Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔲 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

eving

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DO070427

Francis Freisinger, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State	of Marylaı		irtment o <i>tificate</i> o			∕lental Hy	21		01836		
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 📈 Certifying	Physician: To the b	act of my know	yladga dagth a	acurad at the	timo dat	to and place or	ad due to the on	ica(a) and ma		and and		
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Charles	Oberry

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Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)	Oe.	- Illicate Of	Death		2. Date	Reg of Death	. No.	1:	3. Time of Death
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code			100	. Citizen of Wha	it Count	ry?
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Physician		failure. List only one cause	on each line.		i. Do not enter th	e mode or dying, s	uch as card	iac or respira	atory arres	it, snock, or near	١.]	Approximate Interval Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) a. Torso Injuries a. Torso Injuries Due to (or as a consequence of):										Death
		Sequentially list conditions, b										
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.										
_ =	Exami	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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O, be ex sician	edical	UNPENDED	AMENDED									
OX 68760 eath certificate b attending physi		IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg birth		al death 3	Ectopic pr	egnancy		23d. Date of d Month	lelivery Da	y Year
th cert	ပေ၊	past 12 months?		nant at time of de	ath _	ner (Specify)						·
Box he death c / the atten hed for us	Physi		known 9 Unkn				an in Dart I	1 22	a Did tob	nose use centrih	uto to th	e cause of death?
Division of Vital Records, P.O. Box 6876(ital or Attending Physiciao: The law requires that the death certificate ars after death. ral Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the b	Š	Part II. Other significant condit	ions contributing t	o death but not r	esuiting in the u	ndenying cause giv	en in Part i	1				bly 4 Unknown
ords, I	Completed								a. Was ar			psy findings available
COF	ם							- _	autops;	ned? de	eath?	mpletion of cause of
tal Recience: The certificate ector, page		25. Was case referred to medica	1			26 Place o	of Death (Ch	1 Neck only one	Yes 2	No1 _	✓ Yes	2 No
of Vital Records, by Physician: The law requir ufer this certificate has been some director, page 2 should	O B	examiner? Hospital: 4 Insertingly 2 DOA Other Number Hospital: 4 Insertingly 2 DOA Other Hospital: 4 DOA Other Hospital: 4								Scene		
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Sion Attendi death. ctor:	atio	1 Natural 5 Pending Jan 18, 2011 2220 hrs 1 Yes 2 No Driver auto auto collision										
Division pital or Attendio ours after death.	Certification:		ld not be			t, factory, office bu	ilding, etc.			reet and Number ite) 2 and Rt 95, S		I Route Number, City
ospita hours uoera ly fille		4 Homicide	(0,000.)	Interstate/								
Di To the Hospital within 24 hours a To the Fuoeral I completely filled	edical	(Check only Certifying P	hysician: To the be nminer:On the basis	of examination a	_							
To with	¥	29b. Signature and title of certific	and manner : er	stated.		29c. License	number			29d. Date signed	d (Mont	h, Day, Year)
		anele	*			O.C.M	I.E.			January 19,	2011	
r1		30. Name and address of person		•	•							
			sistant Medical			more Street, E	Baltimore,	, MD 2122	23			
St Regist		31. Date filed (Month, Day, Year)	144 A32. R	egistrar's Signati	ure barke	1						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 26, 201 1 Christobelle Iola Phillip 1:22 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore 8217 Selwin Court Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Days Hours 216-13-5059 **Director** 0877771918 Antiqua 92 Usual Residence of Decedent 23a or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural". or itome 990 or 900 to 100. 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Baltimore Rosedale 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8217 Selwin Court 21237 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. 3 X Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Health Aid Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. Ernest Eli Irene Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Selwin Court, Baltimore, Maryland 21237 Janice Christian (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Gardens of Faith 02/05/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 Signature of Funeral Service Licensee 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line. Open and Death Physician/ ase or condition sulting in death) ⊶ Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury bue to (dr as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Certificate: To 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending in 24 hours after com...he Funeral Director: Af 1 Yes 2 No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN

32. Registrar's Signature

WEINER

JAN 28 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Month 15 PM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 5410 Purdue Avenue Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 M M 2 D F October 4. Director 56 218-62-7582 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 1 M Yes 2 □ No N/AMD Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21217 USA 2601 Madison Avenue Apt. 205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Yes 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give **Black** Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Unemployed 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5410 Purdue Avenue Baltimore, Maryland 21239 Darryl Barber, Sr. - Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I 1 Burial 2 Cremation 3 Removal from State Green Mount Cemetery 2/3/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Chatman Harris Funeral Home 21. Signature of Funeral Service Lice 5240 Reisterstown Road Baltimore. Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Vital 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To Division of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) under Au Balt HO 2120 31. Date filed *(Month, Day, Year)* 32. State 8 Registrar

DHMH 17 Rev 7/2009

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CHORLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death IRENE RUESC HER Month Medical DIEN **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 19 Sorrento Avenue Baltimore Baltimore City . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 216-14-9843 1 🗆 M 2 👿 F 9. Birthplace (State or Foreign **Director** 86 Months Hours Min (Month, Day, Ye. Co*untry)* Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at filed within 72 hours after death with the Maryland Director 10c. City, Town or Location Baltimore Baltimore City 10d. Inside City Limits City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 19 Sorrento Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. Completed 3 Divorced 1 ☐ Yes 2XXNo Specify: White Specify Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Parks Nellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mike Proescher (Son) 504 Patomacview Lane Berkley Springs, W VA 25411 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Date 20c. Location - City or Town, State 4 ☐ Dopation 5 ☐ Other (Specify) Meadowridge MEmorial Park 1/25/11 Elkridge, MD Signature of Funeral Service Licensee ²² Name and Address of Facility Gary L. Kaufman Funeral Home at MMP 7250 Washington Blvd., Elkridge, MD 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician/ Interval Between Onset and Death Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 23d. Date of delivery Pregnant at time of death ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 🗆 No Yes 1 Tes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ည 2 No Hospital 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) after death. work? ☐ Accident ☐ Suicide Investigation 6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, e Funeral [City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifi 29c. License numbe

To the Ho within 24 I

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type,

31. Date filed (Month, Day, Year)

JAN 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:16 p M January Henry McDonald Price Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Michigan 1 **₺** M 2 □ F Months Hours 951 Director 59 217-56-5664 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 💆 No Maryland Harford Joppa 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 408 Latimer Road 21085 USA ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 X Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Painting Painter 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Josephine Ellen Vest Bruce Henry Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 Page 1 and 2 Pamela Z. Meadows/Stepdaughter 142 Garnett Road, Joppa, MD 21085 **Itimore**, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ব্য permit. Page 1
Department of
Important: If it
any injury or o ō 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Burnie, MD Glen Haven Mem. Park 1-26-11 4 Donation 5 Other (Specify) 21. Signature Juneral Service Licensia 2. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Rd., A Ba MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** reunine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last signed by the attending physician dbe detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the gause of death? Completed by Pulmoraum 2 🖾 No 3 Probably 4 Unknown 1 Tes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician; T e 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ဂ္ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural
2 Accident
3 Suicide
4 Homicide work? 5 Pending 2 🛂 No Investigation after deat Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by To the Hospital of within 24 hours at To the Funeral D completed filled is Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thesapoalle or Beldir, mo State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0825 Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 7–28–1920 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Min Director 238-50-2449 Usual Residence of Decedent 28a-f show 10a, State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 No Baltimore Windsor Mill 10e. Street and Number 10g. Citizen of What Country? 5518 Old Court Road 21244 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Maritat Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married Maryland 21215-0036 i filed within 72 hours after tal Hygiene. id other than "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. African-American Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked of ရ Joseph Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Mary Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Peoples/Husband 5518 Old Court Road, Windsor Mill, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) King Memorial Park 1-29-2011 Woodlawn, MD Signature of Puneral Service Licensee 22. Name and Address of Facility Whie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part J. Enter the disease, or complications that caused stack, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Retween Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No Yes 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 2 No 1 Yes Other ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attentums within 24 hours after death.

To the Funeral Director: After the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Ratural 5 Pending injury 2 Accident 1 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

2

29c. License number

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PLAYER Month 11 DAM Tamala 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death North WEST HOSPITAL Randallstown Baltimore 5. Social Security Number Birthplace (State or Foreign Country) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🖼 Months Min 5 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Yes 2 No o, 10e. Street and Number 10g. Citizen of What Country? 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 0 Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No "natural", If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. nday (0-12) Elementary/Se College (1-4 or 5+) Be Father's Name (First, Middle, Last) should be file and Mental F is marked o 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or ral Route Num 3906 27 tom MD 21/33 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of I Important: If ite any injury or of 3 Removal from State ■ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. That if the disease, complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Hypoxemia Medical resulting in death) Examiner FIBLOSIS whoraly Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Interstitial Pronuntia sician and burial-transit Due to (or as a consequence of) attending physician Physician/Medical 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed this certificate Division of Vital the Hospital or Attending Physician; 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 - Pending iniury 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January, 24, 2011 D 65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Randallstown, MD Abdollah Kafrouxi 5401 Old Court 31. Date filed (Month, Day, Year) State JAN 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#9perFH,G912,28/2011,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PAROLA 9:20 AM MACIO 2011 inuary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death Mary land Per Health Care System | FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye March 21 eci Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 🗚 2 🗆 F 046-16-6899 Director 84 Vrs 1926 Mi an. Italy Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Bel Air Maryland Harford County ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral to Physician: Parola, Mario Peter 1303 Scottsdale Drive 21015 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. and Mental Hygiene. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. **1943–63** 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Health Physicist Health Reseach injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aldo F. Parola Adele M. Ceci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Diane M. Sexton (Step-Dau.) 121 W. Seminary Ave. Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ♣Cremation 3 ☐ Removal from State (Harford County) Evers Furgario Craftel and Cremation Services, Inc. Friday, Jan. 28,2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 Timonium, Maryland 2325 York Road Timonium, Mary 2325 Y Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner YOUR Sequentially list conditions, Examine Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) detached Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ å, DYSPINDGIA Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should CIMUNIC ASPIRATION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? 2 No certificate 1 Yes Division of Vital Physician: uneral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No ျ Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ofter death Accident
Suicide 1 Yes 2 No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital hours a within 24 hours a To the Funeral D Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my upinion, usaur occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 20390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 31. Date filed (Month, Day, Year) State Registrar

NOW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SADIE 07:47PM JANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, May 2, 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 1 □ M 2 🗓 F Months Hours Min. Director 220-12-5413 86 1924 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3822 New Section Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Cable Lacer Bendix Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clinton Ε. Eckert Sadie Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 19a. Informant's Name/Relationship (Type, Print) Claude H. Phelps/Husband 1650 Woodbourne Avenue, Apt. 108, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1/28/2011 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility of Funeral Service Licey el Bryan W. Uchary emmon Funeral Home of Dulaney Valley Inc. 0 W. Padonia Road, Timonium, MD 21093 23a. Part 1.7 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate aus (Final disease or contion resulting in death) Priysician/ SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 **N**o 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier ekonen, M.D Yasu 264312 JANUARY 23,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard Raven Loch Baltimore

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ADIE

PHELPS

11-00568 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rhidel Price State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 1408 hrs **Medical Examiner** January 20, 2011 Rhidel Price 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 1 X M 2___F 21Yrs <u>216-25-0675</u> 08/26/1989 Md. Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XXYes 2 No Md. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 Cherryhill Road 21225USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1XXNever Married 2 Married Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2XX No specify: Specify: Black Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) <u>Robert</u> В. <u>Katrina</u> Moore19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Katrina</u> 1102 Cherryhill Road, Baltimore, $\underline{\text{Moore}}$ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 1/29/2011 Baltimore, Md. 4 Donation 5 Other Specify Arbutus Memorial 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Estep Brothers Funeral Service 1300 Eutaw Place, <u>Baltimore</u> 21217 Md. Part I. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Mudical Examiner Death a. Gunshot Wound of Torso Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, fall or Attending Physician: The law requires that the death certificate be-IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown After this certificate has been signed by the funeral director, page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 Yes 2 No Hospital or Atteodiog Physiciao: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) æ Other Nursing Home 5 Residence 6 Other. 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification Jan 20, 2011 Subject shot within 24 hours after death.

To the Fuoeral Director: A completely filled in by the fu 1 Natural 1300 hrs Pending 1 Yes 2 V No Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2900 Denham Court , Baltimore , MD (Specify) Local Street 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 21, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPt1,11,25,27,28a=1 per me,9911,01/28/2011dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hester May Rohr Month :00 PM 0 O i Medical 4a. Facility Name (if not institution, give street and number)
Genesis-Cromwell Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days May 19,1922 215-18-9486 1 M 2 XF Months Hours Maryland **Director** 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Perry Hall 1 Yes 2 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 6 Debenham Court items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Administrative to Chief Fire Department 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Malden Surname) ည Hester S. Eaton permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Debenham Court-Perry Hall, Maryland 21236 Bobby Jean Parsley-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Oaklawn Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Jan.22,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fixons Funeral Chapel and Cremation Services 8800 Harlord Read-parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death)) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be CERTIF IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TYPER TENSION Parkinson's Disease 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? OF FREQUENT 24a. Was an has Aspiration Pneumonia autopsy perform DEPRESSION, Severe Malnutrition, ieral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗙 No Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 🌠 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Multiple falls Unknown **Unknown**M Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined or Town, State)
Unknown Unknown within 24 hours a To the Funeral D 29a, Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Kalidmide 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #308 Registrar's Signati State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year 6: 35 PM M Physician/ Ragins Victoria 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Northwest Seasons If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 ... M 2 🔀 F Months Hours Min 02/15/ Maryland ปี967 218-02-1844 43 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No MD Paltimore 10g. Citizen of What Country? 10f. Zip Code 23a or 10e. Street and Number ed other than "natural", or items 23a o event, the Medical Examiner must be by Funeral 3416 Wolcott Ave. 21216 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Keswick College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Home Ith and Mental Hygien 27 is marked other the r traumatic event, the 12th Grade Dietary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Ragins permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Lessie Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miriam Hughes (daughter) 2431 Linden Ave.. Baltimore. MD 21217 altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place)
OSEON H. Brown
OH And Crematory 01/25/11 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Metastatic Breast cancer Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be exec Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed?/ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 - Nursing Home 5 - Residence 6 Tother (Specify) Hospital: 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 읻 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury work? 5 Pending 2 Accident
3 Suicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MS Ryapakse M.D DD057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Av. 5-203, Baltimore, MD. 2120 9-N. S. Rajapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201^{Year} Physician/ 21. S. Raybuck January 1:30 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8505 White Post Court Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y May 16, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 **X** M 2 □ F T920 Pennsylvania Director 072-16-8945 90 May Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heaith and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No New York Allegany Houghton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9727 Genesee Street 14744 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' ģ 1 Never Married 2 Married 1 X Yes : 2 🗌 Baltimore, Maryland 21215-0036 $1942\overline{1}946$ 1 ☐ Yes 2 🔯 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. ulth and Mental Hygiene.
27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laborer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Raybuck Nettie Updegraff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Raybuck (Son) 8505 White Post Ct., Potomac, MD 20854 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Buriel 2 Cremation 3 Removal from State on 5 Other (Specify Pleasant Cemetery 1/29/2011 Houghton, NY 4 Donat 22. Name and Address of Facility
Kopler-Williams Fu
21 N. Genesee St., 21. Sign ature of Funeral Service Licens Funeral Home Fillmore Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anemia disease or condition resulting in death) Medical Due to (or as a consequence of): [']Examiner Recurrent Gastro-Intestonal Bleeding Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Acute Myeloid Leukemia Due to (or as a consequence of) resulting in death) Last Physician/Medical IC CEMALE Completed by Be မ Medical Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. after death Director: / d in by the f completed filled in by

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of delivery Month Day Year									
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
Recurrent Pneum	onia	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown								
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2 No	Hospital: 1									
27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident Investigat	(Month, Day, Year) Injury work? ion M 1 ☐ Yes 2 ☐ No	Describe how injury occurred								
3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - At home, farm, street, factory, office 28f.	Rf. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exa	hysician: To the best of my knowledge, death occured at the time, date and place, and du miner: On the basis of examination and/or investigation, in my opinion, death occurred at the t urse Practioner: To the best of my knowledge, death occurred at the time, date and place, an	ime, date and place, and due to the cause(s) and manner stated								

29c. License number

8218 Wisconsin Ave. #305 Bethesda, MD 20814

D35579

29d. Date signed (Month, Day, Year)

2011

Registrar

within 2 To the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Susan J. Miller, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1Per Phy &18Per FH G912 2/01/2011 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Month Lois Roberts Physician/ Roberts Cono 8:50 A January -Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1955 Sidnee Drive Edgewood If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

Jan. 15, 1 Social Security Number 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Country) Jan. 1933 78 Director 293-26-7004 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 🎦 No Harford Edgewood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21040 USA 1955 Sidnee Drive items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates er than "natur , the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Construction Office Manager is marked other Be 18. Mother's Name (First, Middle, Made Curand 17 Father's Name (First, Middle, Last) ပ Pauline (nmn) Marquard Russell William Krohmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 707 Tulip Court, Edgewood, MD 21040 Janet R. Blackburn / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 1-29-11 Baltimore, Maryland 22. Name and Address of Facility.
McComas Funeral Home, P.A. Signature of Funeral Service Lisensee 1317 Cokesbury Road, MD 21009 Abingdon, 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Metastatic RUCLY -Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Day 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has I page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this In 24 hours after weas...
he Funeral Director: After th funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury Natural 5 Pendina Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Thomas an

E BUY

70026368

Corporate Center Drive, Abingdon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rose 2011 Frances Restivo January 6:00pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oakland Manor Assisted Living Sykesville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 7, **Funeral** 9. Birthplace (State or Foreign Year) 19<u>07</u> Months Country) Director 219-52-5227 103 NY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or items 23a or 28a.4 show 10b. County 10c. City. Town or Location Completed by Funeral Director 10d. Inside City Limits MD Carrol1 1 Yes 2 🔽 No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Kaywood Place 21784 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Force Black, White, etc. 1 X Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify: 3 Divorced 4 Divorced Specify. White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 6 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Restivo Gaetana Curione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra Harrison (Executrix) 102 Scarboro Drive York, PA 17403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1/25/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ emento Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiovascula Alhensclenne 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2★ No Assisted ပ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the I within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

Road

Kidtle

32. Registrar's Signatur

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY ROEGER 20 T 4:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F January 29 Days 025-10-4109 93 Massachusetts Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Completed by Funeral items 23a 21014 U.S.A. 700 High Pasture Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tester 12 Communications To Be traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Luigi Sarto Louise Petrosino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. 700 High Pasture Drive, Bel Air, Maryland 21014 Mr. Paul Roeger (San) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ${f X}$ Burial 2 ${f \Box}$ Cremation 3 ${f \Box}$ Removal from State St. Mary's Mausolen ¡Jan. 31, 2011 Lawrence, Massachusetts 4 ☐ Donation 5 ☐ Other (Specify) Lieuw (M01543) 22. Name and Address of Facility (Property of Figure 1) 22. Name and Address of Facility (M01543) 22. Name and Address of Facility (Property of Facility (M01543) 3. Newport Drive Forest Hill, Maryland 21050 Ptr/ Ent_/ re disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or her it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence Ti: Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? in rever feelung 24a. Was an performed? Yes 2 N 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Director; A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number David 5 032299 January 26,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DAVID DUNN

615 W.

21014

BEL AIR

MACPHAIL ROAD

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:46 A M RIVERA JANUARY 2011 HECTOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BALTIMORE NORTHWEST RANDAUSTOWN JOSPINAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Feb. 10, 1946 XXM 2 D F 64 Puerto Director 093-36-2855 Rico Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2002 Alto Vista Ave. 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married after 1966 1968 Maryland 21215-0036 If Yes, Give Year or Dates. XXYes 2 No Specify: Puerto Rican Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 is narked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Industrial Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Hector Rivera Maria Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gladys Otero / Wife 2002 Alto Vista Ave. Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State A11 Faiths 1 ☐ Burial 2XX remation 3 ☐ Removal from State 1/27/11 4 ☐ Donation 5 ☐ Other (Specify) Manchester, MD rematory & Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Cophac 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ HEART CONGESTIVE disease or condition Medical resulting in death) Examiner AORNE STENOSIS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events certificate be executed ATHEROSCLEROTIC CORONARY VASCULAR and-tran Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical Box 68760 attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No ed by the a 9 Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL DISEASE SMAGE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 🗆 Yes 2 🖢 No certificate Yes the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Or Certifying Myrse Place the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tu 2 29c. License number 29d. Date signed (Month, Day, Year) 20060293 30. Name and address d person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN MD COURT RD, M.D. 5401 OLD State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Jacob Robbins January 2011 6:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 17215 Donora Road Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sep 9, 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F **Director** 220-26-4874 79 Yrs. Pennsylvania Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2X No Maryland Montgomery Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 17215 Donora Road 20905 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates. 1950-52 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Builder <u>Construction</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Minor Robbins Mathilda Marie Butker 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Lynn Robbins-Vinciguerra 7018 Carroll Avenue Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/26/2011 Woodbine, Maryland 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Homas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Acute Myelocytic Leukemia disease or condition <u>Chronic</u> Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 nding p. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 2 🗌 No Yes 2 XNo 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending nours after death.

neral Director: Af
filled in by the fu 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the I

completed 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62234 January 25, 2011

Registrar
DHMH 17 Rev 7/2009

State

Manish Agrawal, M.D. 9707 Medical Center Drive Suite 300 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27 2017 10:45 Pм January Clifton Schreiber, Sr. Albert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 631 Rockaway Beach Avenue ESSEX 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min (Month, Day, Year) 2/03/1924 86 Yrs. Maryland Director 219-14-1712 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h Counts 10d. Inside City Limits 10a. State 10c, City, Town or Location Director 1 ☐ Yes 2XXNo Baltimore Essex Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 21221 U.S.A. 631 Rockaway Beach Avenue or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian the Medical Examiner Armed Forces Black, White, etc. 1943 þ 1 Never Married 2 Married 1 XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", Specify: 1946 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Edmond Schreiber Anna Dannenman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 Rockaway Beach Avenue, Baltimore, Maryland 21221 Dorothy Schreiber (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/01/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Gardens of Faith permit. Licensee ^{22. Name and Address of Facility}
Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death or heart failure. List only one cause Immediate Cause (Final disea, e or condition resulting in death) Physician ancer +4res Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for underted filled in by the funeral director, page 2 should be detached for underted filled in by the funeral director, page 2. in the past 12 months? Month Year Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Μ Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0014221 8.11

Registrar
DHMH 17 Rev 7/2009

223 Eastern Avenue, Essex, Maryland 21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Firozvi, M.D.

31. Date filed (Month, Day, Year)

JAN 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MIQ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice at Northwest Hospital Center Randallstown 8. Date of Birth 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral CountryWirginia Nov 23, Year) 916 1 🗆 M 2 🗆 F 94 Director 213-86-5285 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 🗆 Yes 2 🗹 No Windsor Mill MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21244 2611 Molton Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?/
1 ☐ Yes 2 ☑ No Black White etc. 1 Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 2 🗹 No 1 Tes If Yes, Give Specify: **Black** Completed 3 Wildowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 4th Grade Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Cora Jones Norman Shell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2611 Molton Way Windsor Mill, Maryland 21244 Marvelle Greene - Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Lorraine Park Cem. 1/28/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 21. Signature of Funeral Service Licens 23a. Part 1 Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition resulting in death)

Due to (or as a enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician/ Medical Due to (or as a cons Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy After this certificate has perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Hospital: Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence မ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work' 5 Pending Accident 1 🗌 Yes 2 🗀 No Investigation 24 hours at er death Funeral Director A 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled i by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY SMITH ELIZABETH 6:07 PM DELORES 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF (Month, Day, Yea 01/28/ Months Davs Hours Min. Maryland Director 220-20-8924 79 Usual Residence of Decedent show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ¥ Yes 2 ☐ No Baltimore MD N/A 10e. Street and Number 10g. Citizen of What Country? 901 Cherryhill Rd Apt 359 21225 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 X Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) the self 8th Grade Care Provider marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ೨ John Winfield Green Margaret Moore .. Page 1 and 2 should by tment of Health and Mer tant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Lincoln Dr., Glen BUrnie, MD 21060 Bertha M. Gross(sister) Department of Healti Important; If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/24/11 Woodlawn Cem. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, llams 22. Name and Address of Facility
22. Name and Address of Facility
Brown Jr. Funeral Home PA
2140 N. Fulton Ave., Baltimore, MD21217 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) DECOMPENSATED CONGESTIVE HEART FAILURE DAYS Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLISM 1 DAYS Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by END STAGE RENAL DISEASE, DIABETES MELLITU Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown PERIPHERAL ARTERIAL DISEASE 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 🗌 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pt n 24 hours after death.
e Funeral Director; After th 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) M.D. RES DOOD JANUARY 17,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GANDHI 3001 SOUTH HANDVER STREET, BALTIMORE, MD-21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 28 2011

Denous B. parket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January **Blanche** Shatt1s 26, 2011 1:29 pmM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 C Months Hours (Month, Day, Year) 916 Brooklyn, NY 94 **Director** 061-03-9824 Dec. Usual Residence of Deceder 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director MD 1 Yes 2 No Montgomery Rockville ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? tems 23a 1801 E. Jefferson Street 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 K No and 2 should be filed within 72 hours after 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural" Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Daniel Brainum Sarah Glass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3 Marion Place Island Park, NY 11558 Carol Sobel - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth David Cemetery 1-28-11 Elmont, New York 21. Signature Funeral Service Licensee 22. Name and Address of Facility Gutterman's Funeral Home 175 N. Long Beach Rd Rockville, Centre, NY 2da, Perf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ Pulmonary Fibrosis Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit ause (Disease or rinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\subseteq \text{ No} \) Pregnant at time of death Month Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 24 hours after death.
Funeral Director: After this certificate has been sign Division of Vital Records, Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Accident injury 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0063195 January 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, MD 8600 Old Georgetown Road Bethesda, MD 31. Date filed (Month, Day, Year) State JAN 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Jeanne 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Balt<u>imore</u> <u>Parkville</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year, Jan. 15 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 □ M 2 🔀 F Months Days Hours Min. Director 167-12-1604 90 Yrs Pennsylvania Jan. Usual Residence of Decedent show 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 X No Maryland Baltimore Parkville rms 23a or ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8800 Walther Blvd. Apt. 2614 21234 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Registered Nurse Hospital ge 1 and 2 should be filed wit nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ Kathryn Harrie Stoll Leigh Pearson Light 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Seippel / Son 206 Hood Ct., Churchville, MD 21028 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 1-29-11 Bel <u>Memorial</u> Air, Maryland . Signature Suneral Service License Name and Address of Facility Home, /lee H 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final _VA Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Uisease or imjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 100 the a 9 Unknown 9 Unknown Hospital or Attending Physician; The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No Yes 2 - No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Tyes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗀 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certif P 25 and address of erson who completed cause of death (Nem 23a) (Type, Frint) - Hu Lt 880 F 31. Date filed (Month, Day, Year) IAN 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DOROTHY H. STEVER 26 2011 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Baitimore enter loseph Medical TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X** F Days Hours 10/28/1928 PENNSYLVANIA 161-24-7783 82 Director Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE PARKVILLE 1 🗆 Yes 2 🗚 No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2512 WINDSOR ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3X Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F မ LEWIS COLDREN DOROTHY ROULSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 LYNN KIRKPATRICK/DAUGHTER 5173 ROCKY ROAD GLENVILLE, PA17329 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot GARRISON PORESTOIACO) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/2011 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) VETERAN CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME MO11/39 8521 LOCH RAVEN BLVD. 21286 TOWSON, MD a 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Icer with Abscess. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician be detached for use as the burial P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Degenerative Joint Disease with Severe Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director; After 1 X Natural 5 Pending 1 🗌 Yes 2 🖵 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month. Dav. Year) 26 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jamuary 11:50 PMm 2011 William Hearn Shryock Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Stella Maris Timonium Birthplace (State or Foreign Country) 8. Date of Birth Sept. 11 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 1 M 2 □ F MD 216-28-3405 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 Yes 2 X No 28a-f Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be n Funeral 21042 9801 Michaels Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ō 2 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 🗌 No 1 ☐ Yes 2 X No Specify: White Korea Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 7, ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Metal Casting Wood Pattern Maker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hearn George Forney Shryock Mary 19a. Informant's Name/Relationship (Type, Print)

Mrs. Ernestine S. Shryock (Wife)

St. Elizabeth Hall C105, 2300 Dulaney Valley Road C105

Timopium, Maryland 21093

20a. Method of Disposition

20b. Place of Disposition (Name of Date Date 20c. Location - City or Town, State, Zip Code)

Date 20c. Location - City or Town, State, Zip Code)

Date 20c. Location - City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/28/2011 Owings Mills, MD Garrison Forest Vet. 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL EHOM & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 687 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Tyes Records, Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Accider work? 5 Pending 1 Yes 2 No n 24 hours after death the Funeral Director: A oleted filled in by the fi Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2011 Yreis CRM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD JUSTINE PREIS, CRNP 31. Date filed (Month, Day, Year) JAN 28 2011 32. Registra 's Signatur State Registrar

21,

JANUARY

WILLIAM SHRYOCK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Alice Lee Saylor MA 62:11 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death City Sinai Hospital of Fultimore Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Hours Min. February 21, 1939 71 Maryland Director 213-36-0011 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 4218 Harford Terr. 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Nurses Aid Healthcare any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Dorothy Alice Uttenreither Lyman Lee Myers, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alice Lee Saylor (Daughter) 8712 Roper Road Baltimore, Maryland 21234 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place)
 Parkwood Cametery 20c. Location - City or Town, State January 29, 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Joffrey R. Testerman 22 Name and Address of Facility Evans Funcial Chapel & Cremetion Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 (M01543) 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Septic shock Medical Due to (or as a consequence of): Examiner Metabolic acidosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mperlipiden obesity 1 Yes 25. as case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Res -000 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore. Suraji't Sahe , M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gloria Mildred Trenner 2011 4:55p Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll **Examiner** Sykesville 7200 Third Ave. C - 153Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F April 17 Months Days Hours Min. ^{ar)}192<u>8</u> 82 219-30-5260 MD Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director Carrol1 MD Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral C - 15321784 USA 7200 Third Ave. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ KNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natui jury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Schmeidicke Adolph Andrew Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., C-153, Sykesville, MD 21784 Mr. Jack F. Trenner (spouse) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State All County Cremation | 1-28-11 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Pagestaight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Val disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate

Ent r Inverlying

Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death g Unknown the 9 Unknown nis certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🗴 Residence 6 Nother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 28 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Thomas J. Vento M.D. 114 Business Center Drive Reisterstown, Md. 21136.

29c, License number

165

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 24 2011 7:15 A M Betty S. Williams January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A 6216 Falls Road Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F AUGUST 9, YOF918 VA (Country) Director 92 Yrs 213-38-8269 Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland N/A Baltimore 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6216 Falls Road 21209 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc o þ 1 Never Married 2 Married 1 ☐ Yes : If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural" ¾ Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Vending Machine Operator ARA Food Service 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ William C. Jenkins Rebecca Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Falls Road Baltimore, Maryland 21209 Margaret Selby/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/1/2011 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Timonium, Maryland Dulaney Vally Mem. Gardens 21. Signature of Juneral Service Lious 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Party. Enter the disease, or complications that caused sheck, or heart failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death)

a. Due to for as a Interval Between Onset and Death Physician rebilit Medical (or as a consequente of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Į in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year the 1 ☐ Yes 2 ₽ 9 ☐ Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ, Dementia, CHF, composascular discus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 No certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) this hours after death. neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu d title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TOW SON MO utmes M 6701 N State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00 PM am January 2011 ZL Medical 4a. Facility Name (if not institution, give street and Examiner Town, or Location of Death 4c. County of Death izabeth Cente arsing timor N/A 6. Sex 8. Date of Birth 02-24-1911 Social Security Numbe 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 1 M 2 99 216-18-2252 Director Marvĺand Usual Residence of Decedent or 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Anne Arundel Linthicum 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1205 Furnace Road 21090 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Yes 2 X No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Aro Edna Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Heinbauch (Son) 1205 Furnace Road, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Meadowridge Memorial Park 1/29/11 Elkridge, Maryland me and Address of Facility
Y. L. Kaufman Funeral Home at MMP, Inc.
N. Washington Blvd., Elkridge, MD 21075 21. Signary of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that cause shock, or fart failure. List only one cause on each light death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate C: u e (Final disease or c or dition resulting in eath) Onset and Death Physician/ Medical Due to (or as a consi Examiner Sequentially list conditions, Examine Due to or as a cons if any leading to immedicause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 menths? Month Year Day Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. pothyroidism 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy vinnhomo 2 No 1 Yes Yes Division of Vital 25. Was cose referred to medical Certificate: To Be 26. Place of Death (Check only one, examiner? Other 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death,

To the Funeral Director: A
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2011 anuar 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) venue 2125 and enson

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed Month, Day, Year

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32. Registrar's Signature

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death	item; ner m		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								14. Race - American Indian, Black, White, etc.		
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Mal 2 sho	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty John Walker (H	usband)			_				ood, Ma	-			·	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	tment tant: I jury o		1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification Specification Specif	<i>(</i>)			idge	Memor	ial						yland	
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 Hospit	within 24 hours after To the Funeral Direct Completed filled in Example 1	Medical	29a. Certifier 1 Certifying Physical (Check 2 Medical Examination)	ician: To the best of oner: On the basis of ex	my knowi amination	edge, dea	ath occured vestigation	d at the time, , in my opinio	, date and p	place, and courred at	due to the ca	ause(s) a and plac	ind manne e, and due	r as stated to the cau	d. ise(s) and manner stated.	
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	Stat	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure	Inn	e M	rund	101	110	di	c ~ /	6	1 P	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jamuary 27, Wolfe 201 Tear 12:15 pm Grace Vivian Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2727 Wells Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec 26, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - X Days Hours Min. Virginia Director 226-26-5499 90 Yrs 1920 Usual Residence of Decedent 28a-f show 10b. County 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MD Baltimore Baltimore 1 Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2727 Wells Avenue 21219 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 - Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Henry Sutton Forbes Frankie Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Herbert C. Wolfe, Jr. (Son) 2727 Wells Avenue Baltimore, MD 21219 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 K Burial 2 Cremation 3 Removal from State 2-05-11 Cedar Hill Cemetery Covington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligensee Hall Funeral Home 22. Name and Address of Facility 140 S. Nursery Ave. Purcellville, VA nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 110 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) hours 24 hours Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie M.P. D5722

Registrar

State

FONARD RICH ARASON M.D. 1838 GREENE TREE ROAP #300 ALLESVILLE MA 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) WINGFIELD Month 1757 PM Physician/ THOMAS 2011 anuary Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) Sept 25, 1949 Days Hours Min. Washington, 1 🛛 M 2 🗆 F 61 **Director** 218-56-3023 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 X Yes 2 No 28a-f MD Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Funeral 23a 326 Montgomery Street 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 0 Yes 2 X No Completed by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Construction General Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever Page 1 and 2 should be Betty Ann Sites Robert Clark Wingfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 326 Montgomery Street, Laurel, Maryland 20707 Annette Wingfield 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Jan 28, 11 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389 . Signature of Funeral Service Licensee 1.Will M00773 23a. Part 1. Enter the wisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or his rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): resulting in death) Medical days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physician and ig physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
g Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗹 No 3 Probably 4 Unknown 1 🔲 Yes Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number ,25,2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

PAYAM

31. Date filed (Month, Day, Year)

JAN 28

4940

MOHASSEL, MD.

EASTERN AVENUE

BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18,2011 $\mathsf{JAN}^{\mathsf{Month}}$ ALICE **GERTRUDE** WALDHAUSER 1:25 рМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE NORTH POINT BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 X Days Min 215-28-6473 96 0990977914 ENGLAND Director Usual Residence of Decedent show 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1046 OLD NORTH POINT ROAD 21224 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 Xio Maryland 21215-0036 1 Yes 2 XNo Specify. Completed 3 XWidowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the **CLERK** 12 THE BALTIMORE SUN other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ HERBERT **JONAS** SYER **FLORENCE JACKSON** other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau PHYLLIS MITCHELL/DAUGHTER 311 IMLA STREET, BALTIMORE, MARYLAND 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CROWNSVILLE VETERANS 1/24/11 CROWNSVILLE, MD Signature of Funeral Solvice Licenses 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Netostatio Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause interest Underlying Cause (Disease or iinjury Examine Due to for as a consequence of that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide Investigation 2 🗆 No 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the c within 2 To the F only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) an ひころそらら of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar
DHMH 17 Rev 7/2009

State

MUNESCE

JAN 28 2011

900

and Glen Burnie

MD 21061

7840

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 24. 12:26 P M 2011 Dolores Cecilia Wachter January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore St. Martin's Home Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1-10-1936 Days Hours 1 □ M 2 🎗 F Marvland 75 Director 213-32-0831 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21228 USA 601 Maiden Choice Lane Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Services Administrator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Gorski Jacob Wachter should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 80 King Henry Circle, Baltimore, Maryland 21237 Carol Strine / Cousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a 1 Durial 2 X Cremation 3 D Removal from State injury or 1/26/2011 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition Medical resulting in death) TWO MONTHS Examiner FUERAL YEARS squentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESISTANT URINARY TRACT INFECTIONS. 1 Yes 2 X No 3 Probably 4 Unknown Division of Vital Records, Completed IMMOBILITY. PERIPHERAL VASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 HYPERTENSION. SEVERE DEMENTIA ESSENTIAL 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie D0018362 anal 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE KOMAL K. DANG MD. 3455, Wilkens

State

Registrar

31. Date filed (Month, Day, Year)

JAN 28 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JAN4ARY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death SECOURS 3ALTIMO RE N/A Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 20, 1922 Birthplace (State or Foreign Country)
 Waryland **Funeral** 7. Age (In vrs. last birthday) 1 M 2 K F Director 215-18-3599 88 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21223 2200 Booth Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mattie Mar Nixon Walter Nixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Booth Street Baltimore, Maryland 21223 Sandra Ford Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lansdowne, Maryland 01/26/11 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P Eutaw Place Baltimore, Md 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ E disease or condition Medical resulting in death) Examiner CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury nei Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 ast attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Year Month Day Pregnant at time of death 5 Other (specify) signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2.8 performed? Yes 2 No 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🔲 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident 1 Yes Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 10 0030355 Ve n 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) of Death 3. Time of Death 2. Dat Physician/ 935/M Medical 4a. Facility Name (if not institution, give str 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown **Baltimore** Seasons Hospice @ Northwest Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** 1 🗆 M 2 😿 F Months Days Hours Min n, Day, Year) Apr 1, 1934 219-30-0608 MD 76 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director must be notified MD Howard Columbia 1 🗆 Yes 2 🗗 No ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6306 Tamar Dr. 21045 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the **Public Schools** Custodian traumatic event, Be filed \ 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည **Tommy Crawford** Gladys Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Denise Scott Daughter 6306 Tamar Dr. Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 29, 2011 Ellicott City, MD St. Johns Cemetery 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Sinn dure of Funeral 23a. Part 1. Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buna Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) bed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Tes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending 2 No М 1 Yes Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledg performed at the time, date and place, and due to the days (s)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and fitle of ertifier

31. Date filed (Month, Day, Year)

28

2011

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day J. Butler Orean 2011 6:40 A Medical Jan. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-7-25 Funeral 9. Birthplace (State or Foreign 1 3M 2 Hours Wash 85 Director **247-32-5527** Usual Residence of Decedent 10b. County 10a. State filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director n/a D.C. Washington t¥ Yes 2 □ No 10e. Street and Number 10g, Citizen of What Country? Funeral 127-50th Street, N.E. 20019 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10th D.C. Gov't Meter Reader other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should be Alford Nickelson **Emmily Butler** of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50th Street, Corann Butler/Wife NEWash. DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ב ס ö 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department of Important: If any injury or 1/12/11 Riverdale Park Riverdale, Md. Name and Address of Facility

Hackett's Funeral Chapel, Inc.

NW DC 20011 21. Signatur of Funeral Service Licens W. Nackis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acute Pulmonary Embolism Days Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) le attending physician and ed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b, Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sepsis 1 Yes 2 No 3 Probably 4XJnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed' 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: မှ 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🔲 No neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D69946 1/6/2011 ٤ 35 mer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Emeric Palmer, M.D.

JAN 10

31. Date filed (Month, Day, Year)

1500 Forest Glen Rd. S.S., Md. 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:50 a M 01 01 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dennett Road Nursing Home 0akland Garrett Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days Min. 1 M 2 □ F Yrs. Director 218-38-0701 68 07 31 1942 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Modent Examiner oust be notified at Director 1XYes 2 No MD Garrett 0akland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1113 Mary Drive 21550 Funeral USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dwight Barrick Mildred Burdock ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Barrick PO Box 503, Kitzmiller, MD 21538 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State IOOF Cemetery 1/4/2011 Elk Garden, WV 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21 N. 2nd St, Oakland, MD 21550 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Inellenerge /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş ondiales icate has been się r, page 2 should b 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 450 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) nd

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. 20^{Year} 7:40 PM HAROLD. R. BENSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12831 SELBY ROAD WORCESTER BISHOPVILLE 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
MAR. 6, 1923 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 A F MARYLAND Director 217-36-0514 Yrs 87 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits Director MARYLAND WORCESTER BISHOPVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a Funeral 12831 SELBY ROAD 21813 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **FARMER** 8 AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RANZIE BENSON **EDITH** HUDSON Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JUNE A. HUDSON/DAUGHTER 13132 SELBY ROAD, BISHOPVILLE, MARYLAND 21813 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BISHOPVILLE CEMETERY 1/16/11 BISHOPVILLE, MARYLAND 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part T. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ ona estrue ear D WOG disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) OV onar WOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transit 2007 Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death the a g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other. ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 1 Yes Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Tipleted filled in by determined 24 hours a Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 01-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0344 OH ean State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month 5 \mathbf{p} M 3:30 Lawrence Clarke January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's Larkin Chase Nursing & Rehabilitation Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 12/9/1930 Days 1 X M 2 🗆 F Months Hours Min Director Washington, D.C. 578-<u>40-5862</u> 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director 1 X Yes 2 No Bowie Maryland Prince George's 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? ō must be n Funeral United States 20720 12401 Quiet Owl Lane items 2 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or item edical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1

X Yes 2 □ No 1952—

If Yes, Give

Year or Dates. 1954 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Specify: Black Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Small Business th and Mental Hygiene.
7 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administration Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ၉ Augustine Clarke Sadie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 Quiet Owl Lane, Bowie, Maryland 20720 Lisa Clarke-Bell/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or otl once. Buriat 2 Cremation 3 Removal from State Triangle, Virginia 4 ☐ Øonation 5 ☐ Other (Specify) Quantico National 01/13/2011 22. Name and Address of Facility McGuire Funeral Service, Inc. 20012 21. Signature of Funeral Service Livers 7400 Georgia Avenue, North West, Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) *Examiner End Stage Cardiomyopathy Sequentially list conditions, if any loading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Coronary Artery Disease Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be exe Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ed by the detached Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be det 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident 1 Yes 2 No 3 Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build be build be build be build be build build build build be build bui autopsy death? performed 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this s after death.

I Director: After this
od in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after do

To the Funeral Director

completed filled in by t 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Preference: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certif 얼 29c. License number 29d. Date signed (Month, Day, Year) 1/7/2011 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechi Okwara 12200 Annapolis Road, Suite 316, Glenn Dale, Maryland 20769 31. Date filed (Month, Day, Year)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Ma	arylan		artment <i>tificate</i>			and M	•	_	2011	n	279
			Registrar 1. Decedent's Name (First, Middle	l act)		Cer	lincale	OI D	eatti	-	2. Date of Death 3. Time of Death				
	Physicia Medic		Edward Henr	•	3						Month Jan.	1,	2011 Year		ne of Death
	Examin		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or Location of Death						4	lc. County of Dea	th	
7			Suburban Hos						esda				Montgom		
B	Funeral		5. Social Security Number 082-03-9146	6. Sex 7. Age ★ ③ M 2 ☐ F	e (In yrs. I	ast birthday) 9 4 Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb 1	th y, Year	9. Bi	untry)	ate or Foreign
	Director		Usual Residence of Decedent			9 4115.					Feb 1	3,.	1916		NJ
	ind show at	5	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	le City Limits
	laryla 3a-f s ified	Director	MD Mont	gomery	R	ockvi	11e							1 🗆	Yes 2 X No
	or 28 e not		10e. Street and Number	<u> </u>			10f. Zip (Code				10g. (Citizen of What C	untry?	
	with state	eral	10500 Rockvi	lle Pike,	#31	0	20	852	2			U.S	S A		
	eath tems er mi	Funeral	11. Marital Status	12. Was Decedent E		S. 13. V	Vas Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No-		14. Race - Ame		٦,
9	fter d , or i	by	1 Never Married 2 🛚 Marr		No		Yes, specif				Hican, etc.)		Black, Whit		
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an	be file	인	Herman K. Ca					Ì			P. Je		,		
Maryland	ould mar mati		19a. Informant's Name/Relationsh			19h Mallin	a Address (Stroot or					or Town, State, Zi	n Code)	20852
S	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	Mae Foust Ca			T .							Rockv		
re,	1 and f Hea item othe		20a. Method of Disposition	· · ·	20b. F	Place of Dispos	sition (Name	of			Date		Location - City or		•
altimore,	permit. Page 1 a Department of I- Important: If ite any injury or ot		1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		A.	emetery, crem rling Ceme	natory or oth ton N	erplace [ati	ona	l Fe	b. 24,	Αr	lingto	n, V	A
äĦ	mit. F partm porta / inju		21. Signature of Funeral Service L			Ceme	Name and	Address	of Facility	X 7 7 2	2011		al Hom		
Ä	permi Depar Impol any ir		Cinchen S	of lde		50	0 Un	ive	rsit	у В	lvd. W	ner V.,	Silve	e in Spr	c. ing,MD
	Physician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												mate Between Ind Death
Am 760	cate be executed physician and sthe burial-transit	edical Examiner	d												
1030 A Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 1:4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Feta	ıl death 3 🗌	Ectopic pre Other (spec		,				23d. Date of de Month	livery Day	Year
	quires that an signed to all the detail	ed by P	Part II. Other significant conditio	ns contributing to death bu	ut not res	ulting in the ur	nderlying ca	use give	en in Part I				use contribute to		
\w\ard \	The law red ate has be page 2 sho	Somple								24a. Was autoperfo	osy rmed?	death?	topsy findir completion	of cause of	
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Edward of Vital Re	ng Pl	ite:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of injur (Month, Day,	y Year)	28b. Time of injury	280	. Injury : work?	at	2	8d. Describe h	ow inju	iry occurred		
o i	tendi leath. or: A the fu	iţi	2 Accident Investig	ation			M		′es 2 🗌						
$\subseteq \ge$	nital or At urs after o ral Direct lled in by	al Cert	4 Homicide determi	ned 28e. Place of Injui building, etc.	. (Specify,)					City or Tow	n, Stat			umber,
aste	the Hospital thin 24 hours of the Funeral I	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of r aminer: On the basis of ex Nurse Practioner: To the b	amination	and/or investi	gation, in my	opinion	, death oc	curred at	the time, date a	nd plac	e, and due to the	cause(s) and	manner stated.
	771		29b. Signature and title of certifier	elwan	~N	M		icense i	720				n . 1,)
			30. Name and address of person was Rosemary 31. Date filed (Month, Day, Year)	Wunze, MD	<u> </u>		d Ge	org	etow	n R	d., Be	e t h	esda,	M D	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State	State of Ma	ryland	-	artment rtificate			lental Hy	giene Reg. No.	2011	91880
		Registrar Decedent's Name (First, Middle, La	st)						2. Date of De			3. Time of Death
Physician		Howard Joseph							Month Januar	y 7,	2011	9:50 P M
/Medical	•	4a. Facility Name (If not institution, give				4b. City. T	own, or Lo	ocation of Death	Januar		County of Dea	
Examiner		30744 Gordy 1					elma:				Wicom	ico
Funeral		5. Social Security Number 6. S		(In yrs. la	st birthday)	If Under 1	Year I	f Under 24 Hrs.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
Director			1 🛣 M 2 🗆 F	6	7 Yrs.	Months	Days	Hours Min.	July 2			elaware
	h	Usual Residence of Decedent			,				oury z		775	CIAWAIC
yland	- 1	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
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or 28		10e. Street and Number				10f. Zip (Code			10g. Citi	zen of What Co	ountry?
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fler death with the Marritems 23a or 28a-f skilling in must be rediffed.		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	13.	Was Decede	ent of Hisp	anic Origin? (Sp Mexican, Puerto	ecify Yes or N	0-	14. Race - Ame Black, Whit	
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ours a	2	3 Widowed 4 Divorced	Year or Dates:									
ed within 72 hou ygjene. her than "natura t, it e Madical E		15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usual kind of work	Occupation of the control of the con	on ing most of work	ing	16b. Ki	nd of Business	/Industry
/ithin	-	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. I							
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2 should be filed within 72 hours after death with the Maryland nad Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it e Maricol Examinations to reciffied at To Re Completed by Finneral Director	5	17. Father's Name (First, Middle, Last	/			18. Mother's Name (Fit					Surname)	
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2 sh h and is n	-	19a. Informant's Name/Relationship	,				d Number or Rur					
and lealt	1	Donna Marie Culve 20a. Method of Disposition	er (wife)	206 81				11 Road	De Lm Date	ar, N	D 218 ocation - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mysical Extrair or must be notified at ance. To Be Completed by Funeral Director		20a. Method of Disposition 1█ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ce	ace of Dispo metery, crer	matory or oti	her place)		Date	200. LO	cation - Oity of	Town, State
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permit Depar Impor any in		21. Signature of Funeral Service Lice	nsee		22	2. Name and	d Address	of Facility Sh	ort Fu	nera]	L Home	
20 = 60	4	Uny Ohert	Dewell					ove Stre			DE	19940
_		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death e.	. Do not ent	^	-					Approximate Interval Between Oriset and Death
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/Medical		resulting in death)	Due to (or as a	consequ	ence of):							
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the a	20	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5L	Other (spe	эсіту)					
		Part II. Other significant conditions	contributing to death but	t not resu	Iting in the u	nderlying ca	use given	in Part I	23e, Did	tobacco u	use contribute t	o the cause of death?
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tal or Attending Physician: rs after death. al Director: After this certification by the funeral director p	5	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y ; Ye <i>ar)</i>	28b. Time o Injury		Bc. Injury a Work?		28d. Describe	how injur	y occurred	
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To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29b. Signature and title of certifier	and manner sta	tea.		200	License r	number		29d D4	te signed (Mon	th. Day. Year)
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	-	1/10/1	NASO 1	111	>		1) 6	100		"/	10/2	01(
10 m		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print)	CN	MRRUZI	(2	(1x	HEC O	way ma
State		31. Date filed (Month) Day, Year)	32. Fegistra	r's Signat	ure	, 00	. 01	11/200	/ 51	W 47	- AB	10-14
State Registrar		JAN 112	1011 Jane	ر سه	B. A	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Thomas Lopez Cousar 1448p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 4 – 13 – 1 Days Hours Min. 1 💢 M 2 🗆 F Director 62 218-50-1365 1948 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 No Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 425 Oxford Street 21851 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 □XYes 2 □ No
If Yes, Give Army
Year or Dates. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: spark ack 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Truck Driver</u> Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lucille Baldwin Thomas Cousar, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Warren Cousar/Son Somerset Ave, Pocomoke City, MD 21851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Del Ctr 1/15/2011 Snow Hill, 22. Name and Address of Facility 917 W. Bennie Smith Isabella St. of Funeral Service Licenses Salisbury, MD 21801 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes brill ation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes Vital Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this ð 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending (Month, Day, Year) Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) P DC063904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Gillerice 9733 Healtway Drive, Berlin MD egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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DO

4/13

SB

Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 01882 State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lenore Jane Charlton 6:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death isbur Wicomic at Ö If Under 1 Year Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours Min 223-86-7051 Director 56 06/15/1954 Vi**r**ginia Usual Residence of Decedent show marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Virginia Onancock 1 Yes 2 X No Accomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Hartman Avenue 23417 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: white 3 🛮 Widowed 4 🗌 Divorced Specify. Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Arthur Austin Nellie Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Anderson/sister 1128 Lakeland Dr., Apt. 6, Newport News, VA 23605 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 1/8/2010 Anatomy Gifts Registry Hanover, MD Signature of Funeral Service Holloway runeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARCINOMA disease or condition resulting in death) MALIC LUNG NANT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month ☐ Yes 2 been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of cate has b 24a. Was an autopsy performed Yes 2 death? certificate 1 Yes 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence to SPICIZ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 🗌 Yes 28b. Time of 28d. Describe how injury Natural 5 Pending M 2 🗆 No Accident Investigation after death Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a P 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 8 201 ear 5:05PM Mary J. Crawford January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Nursing & Rehabilitation Center Berlin Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. April 17, 1928 1 □ M 2 F 218-16-7680 82 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2 X No MD Berlin Worcester 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9006 Shop Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Crawford, Mary J. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Essex County Public College (1-4 or 5+) Elementary/Seconday (0-12) Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Powell, Sr. Laura Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 Shop Road - Berlin, Maryland 21811 Charlotte Henry/ Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐XSurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) New Bethel UMC Cem. 15**,**2011 Jan. Berlin, 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel- 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complication, that caused the shock, or heart failure. List only one calve on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest erval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequeritially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 17400 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 V Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) NOK 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month) Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Healthway Dr,

Registrar DHMH 17 Rev 7/2009 Nawid Nastafi,

MÓ

Registrar's Signature

Berlin,

MD 21811

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Mildred Year Clark Rosemarie 12:35 p^M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WOODLANDS-CATERED LIVING OCEAN PINES WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Days 219-12-7945 0471971925 85 Maryland Director Usual Residence of Decedent works any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland 1 X Yes 2 No Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1135 Ocean Parkway 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i ੬ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed 3 XWidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Elizabeth Burrous ပ William J. Davis 19a. Informant's Name/Relationship (Type, Print) Jane C. Starr/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Harpoon Rd., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD Signat re of Funeral Service Licensee 22 Hame and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 dompson cfsp 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) Heart Failure disease or condition resulting in death) Medical Examiner Atrial Ribullation oequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Cormany antery that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical mohouna IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 XN has prior to completion of cause of page certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 🗗 Other (Specify) Hospital 35575F60 ပ္ 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fune 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0066462 1-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Racetrack Rd Berlin MB 21811 Jeffrey R Scheiner D.O. 10514 31. Date filed (Month, Day, Year) 32. egistrar's Signature State AA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5', 40A M Physician/ Coulbourne Maurice Lee ğ 2011 January Medical Racility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5 omic Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. las Sex **Funeral** Country) Maryland Months Days Hours (Month, Day, Year) 08/10/194 221-26-6886 69 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 K Yes 2 No Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 21842 USA items 23a Funeral 10523 Keyser Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 0 1 Never Married 2 X Married Completed by If Yes, Give Navy Year or Dates. 1 Yes 2 No Specify: Specify: "natural", white 3 Divorced 4 Divorced Medical 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) the construction 12 contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Coulbourne Catherine Truitt James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trau 10523 Keyser Point Rd., Ocean City, MD 21842 Karen S. Coulbourne/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/11/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Signatore of Funeral Service Licensee 22 Name and Address Fifacility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Monroson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ears **▶** Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of g physician and stransit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day Pregnant at time of death 2 No been signed by the sahould be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has autopsy page, 2 🗷 No 1 Yes certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🔀 No Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th Completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
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DHMH 17 Rev 7/2009

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6	2+1		30. Name and address of person who comp Style Steel Worth Day Year)	mered cause of death (Item 23a	971	5 Ferninod	Rd, St	303	Bethesda M	us	
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Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-training. Division of Vital Records, P.O. Box 68760

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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Timothy M. Dro	uleti	1- For State Registrar Certificate of Death	lental Hygiene	Reg. No. 201	1 01888						
Physici Medical Exam	an/ iner	1 BIOUICE	2. Date of Month Januar	Death Day Year y 14, 2011	3. Time of Death 0130 hrs						
		4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 4b. City, Town, or Locati		4c. County of Montgom							
Funeral Director		1 11118 - 86 16 36 1	acces Min	.1,1963	9. Birthplace (State or Foreign Country) N • Y •						
Aaryland 28a-f show any	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Montgomery Montgomery Village	ge		10d. Inside City Limits 1 Yes 2 X No						
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10008 Stedwick Road 20886	6	10g. Citizen of What	Country?						
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1983 1 Widowed 4 Divorced If Yes, Give Year 1983 1 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	ican, Puerto Rican, etc.)		White, etc.						
11215-0036 If be filed within 72 hours after death with the Hygiene. **Ansat Hygiene.** **Ansat Hygiene.** **Ansat Other than "unatural?", or items event, the Medical Examiner must be	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner	IOT use retired)		Rental Co.						
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", injury or other traumatic event, the Medical E.	To Be C	Donald T D I	ther's Name (First, Midd Betty Flyn	nn	State 7in Code)						
mand 2 sho tealth and tem 27 is traumati		Susan Basile/Sister 7501 RidgeWel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	ll Court E		e,Md.20705						
timore t. Pages 1 tment of H traut: If i		Burial 2 Cremation 3 Removal from State (Crematory or other place) 4 Donglion 5 Other Specify:	1/18/20	1 Hurley	New York						
		21. St. 1/9 of uneral Service insee 22 Hermany Address of Far	WALDI FUN Dia Blvd.S	NERAL SER Silver Sp	VICE,P.A ring,Md2091						
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line. Acute Combined Drug Intoxic immediate Cause (Final disease a. Methadone and Cocaine or condition resulting in death) Due to (or as a consequence of):	s cardiac or respiratory cation Invo	arrest, shock, or heart Lving Heroi	Approximate Interval Between Onset and Death						
	<u>ē</u>	Due to (or as a consequence of):, Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			·						
nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									
ce be executed ysician and burial - transit	edical	■ MENDED 23a,pt.II,27,28a-f per m	e g912 2-15	5-11 vt							
	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)								
ires that the signed by the lbe detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Coronary Artery Disease, Asthma			e to the cause of death? Probably 4 Unknown						
Division of Vital Records, P.O. Box 6876 in or Attending Physician: The law requires that the death certificat rs after death. In Director: After this certificate has been signed by the attending physelin by the funeral director, page 2 should be detached for use as the	Completed		1 ✓ Yes	topsy prior rformed? deat	e autopsy findings available to completion of cause of h? Yes 2 No						
Vital hysician this cert	S B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 1	th (Check only one) Nursing Home 5	Residence 6 0	ther:						
ision of Attending Ph. or death. rector: After ti		27. Manner of Death Natural 5		e how injury occurred							
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, (Specify) residence	etc. 28f. Location or Town		Rural Route Number, City Crabbs Branch Md.						
To the Hos within 24 ho To the Fun completely:	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of any manner stated.	place, and due to the ca	use(s) and manner as	stated.						
4-9210	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.	er	29d. Date signed (
	-	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, I	Baltimore, MD 21	223							
Sta Regist	ite ar	31. Date filed (Month, Day Year) 32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Francis Michael Dugan 9122 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice WICOMED palisbur4 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. 03/28/1945 65 219-42-7700 Director Usual Residence of Decedent 28a-f shov Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 510 N. Main Street 21830 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2x No Specify. Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) office manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sidney timmons Frances Mae Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Dugan/spouse 510 N. Main St., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 1/8/2011 Hanover, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Billoway function Home Professional Association FOI Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MACIGNANT CARCINOMA OF disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burish-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence HOSPICE ည 1 Inpatient 2 ER/Outpatient 3 DOA Other 28a. Date of injury (Month, Day, Year) Certificate: 27. Mapper of Death Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowledge realth constant of the time, date and place, and due to the o 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUG BUNG 130 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Carl E. Dorsey 2: 13AM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death lisburg 1) icomico 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Min 8-14-1934 West Virginia Director 146-24-4580 76 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fine 77 is marked other than "natural" any injury or other trainer. 10a. State 10b. County 10c City Town or Location Director 10d. Inside City Limits De Sussex Laurel 1 ☐ Yes 2 H No 10e. Street and Number 10f. Zip Code 19956 10g. Citizen of What Country? Funeral 14518 Shiloh Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Owner Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Edwin A. Dorsey Cora L. Conaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Dorsey 14518 Shiloh Way (Wife) Laurel, Delaware 19956 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fifst State Cremation 1-10-2011 20c. Location - City or Town, State Millsboro, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West st. Hannigan, Short, Disharoon F.H. Hennungan Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CBRRBROVASCELLAR ACCIDEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dischi for as a consumumou offi g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Tyes 2 \square No Accident Investigation Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 1)0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

130

2. Registrar's Signatus

WAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

loseph Dolphin	Sta 1- For State Registrar	ate of Maryland	Department o Certificate of	f Health and Mei f <i>Death</i>		2 (1 1 leg. No.	8189			
Physician/	Decedent's Name (First, Middle				Date of Dea Month	ath Day Year	3. Time of Death			
Medical Examiner	Joseph F. Do. 4a. Facility Name (if not institution	lphin	-	4b. City, Town, or Location	January 1	18, 2011 4c. County of Death	1246 hrs			
	48 Old Chestnut Road Elkton Cecil									
Funeral	5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Und	re Min	Foreig	thplace (State or			
Director	171-58-8888 1XM 2 F 47 Yrs. 06/22/1963 Co									
ka	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Locat	ion			10d. Inside City Limits			
nd noce	MD Ceci:	1	E1kton				1 X Yes 2 No			
Maryla Maryla rect	10e. Street and Number			10f. Zip Code	1	l0g. Citizen of What Cour	ntry?			
th the notific	48 01d Chestn		Foreign II O	21921	ining (Servite V	USA	and I dian Block			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent Armed Forces?		is Decedent of Hispanic Or es, specify Cuban, Mexica		White, etc.	ican Indian, Black,			
s after de rall', or niner m	3 X Widowed 4 Dive	orced If Yes, Give Year or Dates:		Yes 2 No specify	<i>/:</i>	Specify: Wh	ite			
hours and maturi	15. Decedent's Education (Spec		during m	it's Usual Occupation (Give ost of working life. DO NO		16b. Kind of Business/I	ndustry			
5-0036 ed within 72 hours 19 yignen. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5	Car H	aular		Trucker				
5-00 ted wit tygien other Com	17. Father's Name (First, Middle,	Last)			er's Name (First, Middle, I					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	Gerald Dolphi				ianne Gorma					
hou hou lis is is	19a. Informant's Name/Relationsh Susan Dolphin/			Address (Street and Nu terling Rd.						
e, ML l and 2 s Health ar item 27	20a, Method of Disposition		20b. Place of Dispos	ition (Name of cemetery,	Date 1/20/2011	20c. Location - City or	Town, State			
imore, MD 2 Pages 1 and 2 shoul nent of Health and Intem 21 it item 21 item or other traumatic	1 Burial 2 X Cremation 4 Donation 5 Other Sp			_{d Funeral Ho}		Rising Sun	, MD			
Baltimore, MI permit, Pages I and 2 s Department of Health a Important: If item 27 injury or other fraum	21. Signature of Funeral Service			ame and Address of Facili T. Foard Fun 9 E. Main St						
	23a Part I. Enter the disease, or	complications that caused	the death. Do not enter t	9 E. Main St	. Elkton, M	D 21921 est shock or heart	Approximate Interval			
Physician /Medical	failure. List only one cause	on each line.) Intoxicati		,,	Between Onset and Death			
Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		HILOXICACI	<u> </u>					
a	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	duence of):							
Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c								
Exa ansit	events resulting in death) Last	Due to (or as a conse	equence of):							
6 be executed system and burial - transit	X UNPENDED		Ba,pt.II,27,	28a-f per me	g912 2-9-1	1 vt				
760, ficate be g physici the buri	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome		tal death 3 Ectop	ic pregnancy	23d, Date of delivery Month D				
Box 6876 e death certificate the attending phy ed for use as the t hysician/M	past 12 months?	4 Pregnant at	time of death	tal death 3Ectop her <i>(Specify)</i>	ic pregnancy	World	Day Year			
). Box 6876 the death certificat by the attending phyche at se as the Chysician/M	Part II. Other significant condition	9 Olikiowii	to the state of th	anderbijen en en einen in D	land I 220 Did to	obacco use contribute to	the seven of death?			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly brilling that To Be Completed by Prification: To Be Completed by	The state of the s	e Cardiovaso	_	nderlying cause given in P			pably 4 V Unknown			
Records, The law require. freate has been sig., page 2 should be					24a. Was		topsy findings available			
Recol The law cate has l page 2 sh					autop perfor 1 ✓ Yes	rmed? death?	completion of cause of			
ital Reisin: The certifica rector, pa	25. Was case referred to medical			26.Place of Death	(Check only one)		3 2 110			
f Vita Physici or this coral direc	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie				Residence 6 🗸 Other	: Scene			
n of ding Ph	27. Manner of Death 1 Natural 5 Pendi	28a. Date of Injur (Month, Day,Ye	ry 28b. Time of I	njury 28c, Injury at Wor		how injury occurred				
isior Attencer death rector: by the	2 Accident Inves	tigation 28e Place of Ini		n et, factory, office building, e	unknow		ral Route Number, City			
Division or spital or Attending, norms after death. normal Director: After filled in by the fune. Certification:	3 Suicide 6 X Could determ		residence		E1kton,	Street and Number or Rustate) 48 OLd C	hestnut Rd.			
Division of Vital Records, P.O. Box 6876(To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	(Official drift)	ysician: To the best of my	- ·							
To the Ho within 24 I To the Fu completely	one) 2 Medical Exam 29b. Signature and title of certifier	and manner stated.	mination and/or investigat	29c. License number		29d. Date signed (Mon				
	WH K	11 mD		O.C.M.E.		January 19, 2011				
	30. Name/and address of person	who completed cause of de	eath (Item 23a)							
	Melissa Brassell, MD	Assistant Medical		. Baltimore Street, E	Baltimore, MD 2122	23				
State Registrar	31. Date filed (Month, Day, Year) JAN 2.8 2011	32. Registrar	's Signature							
DHMH 17 Rev 1/2001	OGME	Come d.	ORIGINA	L		-				
OCME 2006										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Maryla		artment of F rtificate of		Mental Hy	giene	011	01892	
	Physicia	_	1. Decedent's Name (First, Middle, La Mabel I. Fulk	st)					2. Date of De Month 01	Day 05	2011	3. Time of Death 4:30 p M	
	/Medic Examin		4a. Facility Name (If not institution, given 215 Kendall Lane				Cre1				4c. County of Death Garrett		
-	Funeral Director		216-18-1330	Sex I□M 2 X F		96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	rth a <i>y, Year)</i> 26 191	Cou	place (State or Foreign intry)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Garre 10e. Street and Number 215 Kendall Lane 11. Marital Status 1	12. Was Dec Armed F 1 Yes If Yes, G Year or I ducation ade completed College t) cmilk (Type. Print) yle-dat Removal fron fy)	cedent Ever in orces? 2 No ive Dates: (1-4or 5+) aghter 20	19b. Mailin 4211 b. Place of Disportementary, cre. Ashby Ce	n 10f. Zip Code 2155 Was Decedent of If Yes, specify Cub If Yes, specify Cub If Yes 2√√ No dent's Usual Occup kind of work done DO NOT use retire housekee Hutton R position (Name of matory or other pla	pation during most of word) 18. Mother's Na Bessi and Number or R oad, Oak 1/8 ass of Facility Dar	me (First, Middle e A. Cas ural Route Numl land, MI Date /2011 vid A. I	USA Spot 14. Spot 16b. Kind of 17 Steel 16ber, City or Tot 21550 20c. Locati Crel Burdock	14. Race - American Indian, Black, White, etc. Specify: White ind of Business/Industry medical Surname) or Town, State, Zip Code) bocation - City or Town, State ellin, MD		
P.O. Box 68760,	the death certificate be executed Whe attending physician and action and action and action a	Physician/Medical Examiner	23a. Part1/ Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d. 23c. If yes, o	o (or as a con-	sequence of): sequence of): sequence of):	der the mode of dyl	ease	c or respiratory		. Date of deli	Approximate Interval Between Onset and Death Mon To	
Division or Vital Records, P.	al or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and all Director. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	25. Was case referred to medical examiner? 1 Yes 25. Was case referred to medical examiner? 1 Yes 25. Was case referred to medical examiner? 1 Yes 25. Was case referred to medical examiner? 1 Yes 26. Place of Death (Check only one) 1 Yes 27. Was case referred to medical examiner? 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury work? 28d. Describe how 1 Yes 2 No 28d. Describe									24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No Other (Specify) Injury occurred		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	(Check only 2 Medical Ex-	aminer: On the	he best of my basis of exar anner stated.	knowledge, dea mination and/or i	th occurred at the nvestigation, in my	opinion, death oo	ce, and due to th	e, date and pl	ace, and due	e to the cause(s)	
	with To 1	M	29b. Signature and title of certifier	Rech	the	2	D30	ise number		11	5/20	h, Day, Year)	
7		2	30. Name and address of person wh	completed ca	use of death ((Item 23a) (Type 2 7 Me	Print) MORIAC back	Drive	OAK	(AND)	no.	21550	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN - 7	2011	Merces	. 1. 4	ball						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vance Douglas Fields <u>23:56 ₽́M</u> January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Union Hospital of Cecil County Elkton Cecil 8. Date of Birth
(Month, Day, Year)

April 26, 1946 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 L F Months Days Hours Director 218-42-4873 64 Kentucky Usual Residence of Decedent or 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2XXNo <u>Maryland</u> Cecil North East 10e. Street and Number 10g. Citizen of What Country? Funeral 66 Crows Food Drive United States should be filed within 72 hours after death v and Mental Hygiene. 'is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: "natural", Specify: White 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Master Electrician Manufacturing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Raymond Fields Evelyn Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 66 Crows Foot Drive, North East, Maryland 21901 Amy J. Fields / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Mayerdale Crematory 2011 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and-trans Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year the 9 Unknown signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1NO Other: 1 Yes ပ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practicer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) Bou State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Robert Bryan Griffin Jr. 0900 Medical January 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death c. County of Death
Montgomery 512 Pershing Drive Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Days Hours 95 1072577915 Wasty., DC **Director** <u>578-07-8826</u> "natural", or items 23a or 28a-f show dical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State **Mď** 10b. County Montgomery 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20910 512 Pershing Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates. WWII permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Broker Real Estate 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame) Adele M. Marshall Robert Bryan Griffin Sr. ည 19a. Informant's Name/Relationship (Type, Print)
Grace M.Griffin/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Pershing Drive Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Dother (Specific Mt.Olivet Cem. 1/8/2011 Washington, DC Signature of uneral Septice PHILIPADE RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Chronic Obstructive Pulmonary Disease disease or condition Not Stated Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s perform 1 Yes 2 No Yes 2X No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work'i Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Certifying Ninese Practioner: In the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29b. Signature and title of certifier 29c. License number Whom themin MD #ME91750 January 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert M. Kaiser, MD VAMC, 50 Irving Street NW Washington, DC 20422 31. Date filed (Month) Day, Year) 32 Registrar's Signatu State Registrar

11-00514 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Danny Wayne Harding, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** 1905 hrs January 18, 2011 DANNY WAYNE HARDING, SR. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign MARYLAND Days Months Hours Director 220-84-0509 1 M 2 F 48 12/06/1962 Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MARYLAND DORCHESTER RHODESDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5521 INDIANTOWN ROAD 21659 USA 238 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 2 X No WHITE 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 GRAIN 12 FARMER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked o
injury or other tranmatic event, th Be HOWARD CLYDE HARDING BETTY SEWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 STONE BOUNDARY ROAD, CAMBRIDGE, MD 21613 BETTY PARKS/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State EAST NEW MARKET CEMETERY 1/24/2011 EAST NEW MARKET, MD Donation 5 Other Specify 22. Name and Address of Facility
ZELLER FUNERAL HOME, P. O. BOX 207
106 MAIN STREET, EAST NEW MARKET MD 21. Signature of Funeral Service Licens 21631 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Enter the disease, or complications th Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Markey) Death Multiple Injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Ca AMENDED 23a, 27, 28a-f per me g912 2-4-11 vt X UNPENDED Division of Vital Records, P.O. Box 68760, tending phys IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autonsy findings available prior to completion of cause of autopsy has death? Dage ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No 28b. Time of Injury After 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred pedestrian struck by motor 1 Natural 5 Pending 1 Yes 2 X No Director: I in by the f 1 - 18 - 116:00pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5521 Indiantown Rd. Rhodesdale, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after of Funeral Direc 3 Suicide Could not be determined field 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 19, 2011 a 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signatur State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month 4:35 рм January 6, John August Kopsitz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 12, 1927 9. Birthplace (State or Foreign **Funeral** 1**₹** M 2 □ F Months Days Hours Min. Country) PA 83 Yrs. **Director** 579-24-7044 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County with the Maryland Director 10c, City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Gountry? Funeral 4505 Mahan Road 20906 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1★ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 V Widowed 4 Divorced Year or Dates. 1945-46 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working than Heating/Air College (1-4 or 5+) Elementary/Seconday (0-12) Conditioning I Hygiel Sheet Metal Journeyman permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Adams Kopsitz Elizabeth Rack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Phillips/Daughter 4505 Mahan Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗵 Burial 2 🗌 Cremation 3 🗌 Removal from State 11, George Washington Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signatur of Funeral Service Licen Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or conions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tuse on each line, shock, or heart failure. List only o Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Esophageal Cancer vr Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buna Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown d detach β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy perform Yes 2 X No 2 🗌 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes 2 **X**No 1 Marient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. ☐ Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the I **E** only one

State

Registra

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

George A. Sotos, Md

n

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d, Date signed (Month, Day, Year)

Jan. 8, 2011

D43083

9707 Medical Center Drive, #300, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Certif	icate o	f Death	7				Reg. No.			
Physicia ledical Exami	an/	Decedent's Name (First, Mary Jane								-		Date of De Month January	Day	Year	3	3. Time of Death 1900 hrs
		4a. Facility Name (if not ins			umber)			4b. City, T		ocation of	Death			unty of [Death	
		3400 Block Maryl		ay ———	7 4 //	lt	hiadh al a . A	Oakla		K I loder	241/50	9 Date of B	Garı irth(MM/DD/		Dieth	place (State or
Funeral Director		5. Social Security Number 234-40-3394	6. Sex	M	/. Age (I	n yrs. last		Months	1 Year Days	If Under Hours	Min.		`		oreign	
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re, MC 1 and 2 st Health ar fitem 27		20a. Method of Disposition						sition (Nam	e of ceme	tery,		Date	20c. Loca	ition - Ci	ty or To	own, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Crer 4 Donation 5 Oth		Removal f	rom State		matory or o a Alt	a Cem	eter	,	1/5	/2011	,	Геrr	аА	lta, WV
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	ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying C	Du	ie to (or as a	a consequ	ence of):										
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Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 No 9	Unknown	9 Unkn												
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of V ing Phys After thi uneral di	은	1 ✓ Yes 2 No 27. Manner of Death		28a. Date	of Injury	28	b. Time of			at Work?			how injury o		Juliet. 0	
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Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certies thours after death. Funcral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use a	Certification	4 Homicide	determined		Local	Street					34	or Town, 00 Block N	Maryland Hi	ghway	, Oakla	and, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ical	TOTICON OTH)	ng Physician Examiner: C													
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		30. Name and address of p	erson who on	moleted cou	se of death	h (Item 22-	a)									
	5	Victor Weedn MD	JD Ass	istant Me				V. Baltim	ore Str	eet, Ba	ltimore	, MD 212	23			
St	ate	31. Date filed (Mor #144),	ea 201	32.	egistrar's S	Signature	1									
Regis	rar		Troi	· Le	run	<i>A</i> .	190	Med								
DHMH 17 Rev 1/2	001		OCME			C	PRÍGINA	L								

			For State	State of M	/larylan	-	rtment of h		and M	lental Hy	giene	2011	31	898
			Registrar	4)		Cer	tificate of L	Jeath			Reg. No.			
	Physicia Medic		1. Decedent's Name (First, Middle, Las Theresa I		ıc					2. Date of Dee Januar		, 20 1 1	3. Tim	e of Death M
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, o		of Death	-	4c.	County of Dea	th	
	,		Brighton Gardens				Colum					Howar		
	Funeral Director		33Z-03-Z34I	- R#	.ge (In yrs. Ia 92	ast birthday) Yrs.	If Under 1 Year Months Days	If <u>Under</u> Hours	24 Hrs. Min.	8. Date of Birt	6 ^{Year)} 1	918 ^{9. Bir}	thplace (Sta	te or Foreign inois
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside	e City Limits
	larylar 3a-f s iified	Director	Maryland Howard	1		Columb	ia						1 🗆	Yes 2 🔼 No
	or 28		10e. Street and Number				10f. Zip Code		-	- 1	10g. Citi:	zen of What Co	ountry?	
	s 23a	Funeral	7110 Minstrel Way	Unit 35	54		2104	5		T.		USA		
	death item		11. Marital Status	12. Was Decedent Armed Forces 1 \(\subseteq \text{Yes} \) 2 \(\text{Yes} \)	Ever in U.S		Vas Decedent of H Yes, specify Cuba	ispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit		,
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No	1	☐ Yes 2 No	Specify:					√hite	
ğ	hours natura lical E	lete	15. Decedent's Ed	lucation			ent's Usual Occup				16b. Kir	nd of Business	Industry	
215	in 72 e. han "ı e Mec	Completed	(Specify only highest gra	de completed) College (1-4 or	5+)	life. Do	ind of work done of NOT use retired)	during most	t of workir	ng			·	
7	d with lygien ther th	Be C	12			S	ales					tail		
Maryland 21215-0036	be filed ental Hy ked oth ic event	10 B	17. Father's Name (First, Middle, Last) Daniel Albino							(First, Middle, Esposit		lurname)		
ary.	12 should be file alth and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street					Town, State, Zi	D Code)	
ž	d2shaltha altha 27is		Gary W. Kuc	son		1	Autumn W				. ,			43
ore,	of Heal of Heal if item ?		20a. Method of Disposition 1 Burial 2 Cremation 3	Romoval from Stat	_ 0	emetery, crem	sition (Name of actory or other place	ce)	D	ate		cation - City or		
<u>H</u>	Page tment o tant: If jury or		4 Donation 5 Other (Specify		St.	Mary	Cemetery			7 2022		and, Ca		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	9	5		Name and Addre							Inc. 21043
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that cause le cause on each lir	ed the death	h. Do not ente	r the mode of dyin	g, such as	cardiac or	respiratory arr	est,		Approxi	mate Between
	nysician/	5 6	Immediate Cause (Final disease or condition	Cardio	myopa	athy								nd Death
-	Medical Examiner		resulting in death)	Due to (or as		_{lence of):} Iyperte	ngion						15	
		Jer	Sequentially list conditions,	b. Due to (or se			TISTOII						15 ye	ars
	nted d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury											
	ate be executed physician and the burial-transit	EX	that initiated events resulting in death) Last	Due to (or as	s a consequ	ience of):								
9	ate be ohysic the bu	dical		d										-
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	ncv						od Data of I		
ŏ	eath c atten	iciar	in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant	2 Feta at time of d	I death 3	Ectopic pregnand Other (specify)	у				23d. Date of de Month	Day	Year
P.O. Box 687	the de by the achec	hys	9 Unknown	9 Unknown										
9.	s that gned I	by F	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I	l.			se contribute to		
rds	een si	eted	DGIRICIA							1 🗆 ነ	Yes 2L	X No 3 □ P		
900	has b	Completed by Physician/Me								24a. Was a autop		24b. Were au prior to death?	topsy findin completion	gs available of cause of
ž	n: The ficate or, pag		25. Was case referred to medical					ace of Deat	th (Charle	1 Yes	2X No	1 Yes	s 2 🛭 No	
Vita	ysicia s cert direct	To Be	evaminer?	Hospital:	tient 2 🗆	ER/Outpatien	Oth	er:		ne 5 🗆 Resid	lence 61	M Other (Spec		isted
Division of Vital Records,	lor Attending Physician: The law requires that the death certificate be executed attendent. Birector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2.	Certificate: 1	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of inj (Month, Da	ury	28b. Time of injury	28c, Injun work	y at	2	8d. Describe h			^{cify)} Li∨	ıng -
Sio	Atten er dear ector; by the	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At ho	me, farm, stre	et, factory, office	100 2		28f. Location (S		Number or Ru	ral Route Nu	ımber,
2	ital or irs afte al Dir			building, e	tc. (Specify))			1	City or Tow	n, State)			
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one) 3 Certifying Nurs	ner: On the basis of	examination	and/or investi	gation, in my opinio	on, death oc	curred at 1	the time, date a	nd place,	and due to the	cause(s) and	manner stated.
	To the community of the		29b. Signature and title of certifier	Ac	m	D	29c. License	number			29d. Date	e signed (Month	h, Day, Year)	
			<u> </u>	4				6531			Jaı	nuary 1	.3, 20	11
,	,2		30. Name and address of person who c Harry Li 8600	ompleted cause of Snowden				Colu	mbia.	, MD 2	1045			
	Stat	е	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure		-010						
	Registra	ır	JAN 1 4 20	111 Ares	andi	B. Do	arkal							

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		_ FOI	eartment of Health and Mental Hygiene ertificate of Death	01899
Phys		1. Decedent's Name (First, Middle, Last) Marquerite W. Lacy	2. Date of Death Month Jan. 4, 2011	3. Time of Death 11:00P M
	dical niner	A. E. W. Alice of the street o	4b. City, Town, or Location of Death 4c. County of Death	
		Garrett Co. Memorial Hospital	Oakland Garrett	
Funer Directo		5. Social Security Number 420-42-5045 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 79 Yrs.	If Under 1 Year	ace (State or Foreign ry) . bama
and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or I	Ocation 10	d. Inside City Limits
Maryla f sho	į			1 □Yes 2 No
the h	Director	MD Garrett McHer	11 Y 10f. Zip Code 10g. Citizen of What Count	
h with		529 Wagner Road	21541 U.S.A	. •
ems ar mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - America Black, White, et	
after ;	\d		1 □Yes 2 X No Specify: Specify:	
hours a	d be	I 3 Mar Wildowed 4 LI Divorced Year or Dates:	Wh:	ite
in 72 in 72 in "in a	plet	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin life.	e kind of work done during most of working DO NOT use retired)	25ti y
d Z IZ 15-UU30 filed within 72 hours after death with the Maryland Hygiene. Whet than "natural", or items 23a or 28a-f show ent, the Marical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Cred	it Investigator Universal	CIT
yidilia Z 1 Z buld be filed with Mental Hygiene, arked other that	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
aryid should land Men s marke umatic	٦		Eola Mae Marsh	
d d d d d d d d d d d d d d d d d d d			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Wagner RD. McHenry, MD 21541	Jode)
s t and 2 of Health item 27 i		20a Method of Disposition 20b. Place of Disp	position (Name of Date 20c, Location - City or Toy	vn, State
rmit. Pages partment of portant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremate	yside 1/7/2011 Davidsvill	e. PA
permit. Pages 1 am Department of Heal Important: If Item 2 any Injury or other	once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Newman Funeral Home	es P.A.
		23a. Part 1. Enter the disease, or complications the complete the death. Do not e	179 Miller St., Grantsville, MD ter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Physicia	ın	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Onset and Death
/Medica	_	resulting in death) Due to (or as a consequence of):		-1
LXamme	•	Sequentially list conditions, if any, leading to immediate	0r	north
uted 1 Insit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	١	mantes
exect an and rial-tra	Exa	resulting in death) Last C. Due to (or as a consequence of):		(6)
ficate be executed physician and sthe burial-transit	edical	a Radiation E	sophagitis	7 months
eath certific attending p for use as t	Med	IF FEMALE:		
eath c attence for us	cian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy 23d. Date of deliver ☐ Other (specify) Month I	ry Day Year
Lires that the de signed by the a	Physician/M	1 □ Yes 2 ☑No 9 □ Unknown	Done (specify)	
S, T is that yned t	Þ B	Tart II. Other significant conditions contributing to death out not resulting in the		a cause of death?
w require s been signated by			(GV (INding 1 Yes 2 No 3 Proba	ably 4 🗌 Unknown
e law r has be e 2 sh	Completed	of forthered spread to me	autopsy prior to com	sy findings available apletion of cause of
ding Physician: The In. After this certificate hit	ပ္ပ		performed? death? 1 □ Yes 2 □ No 1 □ Yes	2 □No
siclan certif rector	Be		26. Place of Death (Check only one)	
Physer this eral di	2	12 inpatient 2 EH/Outpati	THE STILL STILL BOOK 4 Inversing Home STILL Residence 6 Invertebrate (Specify)
ath. r: Afte	atio	1	Work? 1 □ Yes 2 □ No	
r Atte ter de irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural City or Town, State)	Route Number,
oital o urs af eral Di				
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1	ith occurred at the time, date and place, and due to the cause(s) and manner as st. nvestigation, in my opinion, death occurred at the time, date and place, and due to	ated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, D)ay, Year)
		type in	00061801 1/6/11	
	6	30. Name and address of person who completed cause of death (Item 23a) (Type	suite, anklard up 21550	
5	State	31. Date filed (Month, Pay Year) C 2011 32. Registrar's Signature	Ladd	
Regis		DAIN - 6 2011 Senus B. 1	and the same of th	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per med cert G912 2/2/11 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 January 08:32 AM Medical John L. Loban 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Abbey Manor Assisted Living E1kton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day Ye)
Dec 3, 9. Birthplace /State or Foreign deary isburg Pennsylvania Funeral 1 X M 2 🗆 F **Director** 89 Yrs Ĩ921 179-12-5608 Usual Residence of Decedent ms 23a or 28a-f show must be notified at ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director North East Maryland Cecil 1 Tes 2xxNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 United States 143 Bennett Avenue, Chesapeake Isles 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: Completed 3¥¥Widowed 4 ☐ Divorced Year or Dates.US Navy the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Owner Retail</u> Sales Hardware : If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) регтіt. Page 1 and 2 should be file Department of Health and Mental [§] Important: If item 27 is marked o ၉ John E. Loban Mary Livingston 19a. Informant's Name/Relationship (Type, Print) 1993Maijing Address Street and Number or Gyral Royte Nymber C'itas Towns State, Zip Code) North East, Mary Land 21901 Barbara Manges / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 13, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury or 2011 4 Donation 5 Other (Specify) Mayerdale Crematory Newark, Delaware Signatus of Funeral Service Lic 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryalnd21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NTERSTITIAL disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): FMPHYSENA Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed PULMON ARY GBROSI that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner To the basis of my knowledge death occurred at the time. Letter and place and place and place and place and place. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) North DOO 65733 12/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-11VA FLKNN, 1024921 NARAYAJA RAO V PULA 126 A E- 17/14 I Treet 61. Date filed (Month, Day, Year) 32. Redistrar's Signature State park Registrar

ALE

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13^{Pay} Physician/ Menth 2011 5:10 A M Agnes Lee McCarty Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospice Burtonsville 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours 5/47/1931 an Director 201-26-3837 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia MD Howard 1 Yes 2 No 10f. Zip Code 21045 Street and Number 10g Citizen of What Country? United States 5761 Twelve Month Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ğ 1 Never Married 2 Married Yes 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Teacher Be 17. Father's Name (First, Middle, Last) Frank Shultz 18. Mother's Name (First, Middle, Maiden Surname) Ellen Sabo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5761 Twelve Month Ct. Columbia, MD 21045 Wayne McCarty - Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Columbia Mem. Pk. 01/17/2011 Clarksville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc . Signature of Funeral Service Licens 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year n signed by the a Id be detached for ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b irector, page 2 st autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 2 1400 မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation within 24 hours after deatl

To the Funeral Director;
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue, Ballemone MA

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

RECEA

or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital**

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month Day, Year) **2011**

do

Ve

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NA TESAN

32 Registrar's Signature

DHMH 17 Rev 7/2009

1415

29c. License number

147094

sher V

29d. Date signed (Month, Day, Year)

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1424 M Sewell Milbourne, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICMICO REGIONAL 8. Date of Birth
7 (Month, Day Year
7 - 5 - 1 9 2 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral X M 2 □ F Days 89 Director 216-14-2363 MĎ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Snow Hill MD Worcester 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral USA 5534 Blake Road 21863 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married 1 Yes If Yes, Give 3 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Spedulack 3 XWidowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tyson Foods Truck Driver 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sewell Milbourne, Sr. Margie Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1252 Courtney Lane, Bel Camp, MD21017 Darlene Milbourne/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-15-2011 Snow Hill, MD Wesley Cem Interest Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the lisease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Myo cardeal Intarction disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending phase as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Small Bowel Obstruction 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 \sum No this certificate has 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one Be 1 Ves 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Hospital or Attending work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1-1-2011 029105 Areddleston of person who completed cause of death (Item 23a) (Type, Print) M.O. 104 MILTENO SAUSBUM MO

Registrar

DHMH 17 Rev 7/2009

1-00126 /alerie Orr Bur	steir	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		egible.	01005
		1- For State Registrar Certificate of Death	, 0	Z U I I	11303
Physic		Decedent's Name (First, Middle,Last)	2. Date of De	_	3. Time of Death
Medical Exam	ıne	valente on valente on bursten	January	4, 2011	1310 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4808 Moorland Lane # 1201 Bethesda		4c. County of Deat Montgomery	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8 Date of B	Birth(MM/DD/YYYY) 9. Bi	tholace (State or
Director		226-54-7321 1 M 2X F 70 Yrs. Months Days Hours Min.		Forei	gn Duntry) New York
		Usual Residence of Decedent	100722	2/1940	New IOIK
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ğ	Maryland Montgomery Bethesda 10e. Street and Number Life Zin Code			1 Yes 2 X No
or 28	Director	10f. Street and Number 10f. Zip Code 20814		10g. Citizen of What Cou United Stat	•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Ar 72 is marked other than "natural", or items 23a or 28a-f she mastic event, the Medical Examiner must be notified at once		1			ican Indian, Black,
death r iten	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	ican indian, plack,
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir		16b. Kind of Business/	Industry
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5-00 ed with tygien other	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Museum Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Charles Slater Virginia		,	
Should and Me is ma	^L	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
- 고등등		Steve Bursten, Spouse 4808 Moorland Lane #12 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.			
Baltimore, permit. Pages I at Department of He important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	·
Itimen ritmen ritmut		4 Donation 5 Other Specify: Ft. Lincoln Crematory 01/1 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Circumstance 25.	13/2011	Brentwood,	Maryland
Ban Depa Inpo		Inn Pous Hours	- OT-		
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∖Medical ≞xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries			Between Onset and Death
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cords, P.O. Box 68760, law requires that the death certificate be emas been signed by the attending physicial should be detached for use as the buria	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	11 46	23d. Date of delivery	
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Division of 'To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discovered at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and the time, date		Bethesda, Me	
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tand manner stated.	the time, date	and place, and due to the	cause(s)
H × H 3	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
		Afler Brassel Was		January 5, 2011	
		30. Name and address of person who completed cause of death (Item 23a) Malissa Brassell MD Assistant Modical Examinar 200 W Bultimars Street Baltimars	MDC:0=	2	
51	ate	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore 31. Date filed (Month, Day Year) 32. Registrar's Signature	e, MD 2122	<u> </u>	
Regist	_	JAN 20 2011 2 A. A.			

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Jose Mar 19a Informant's Na				19b	. Mailing Add	ress (Stre			a Pir		v or Town	State	Zip Code)
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Divisi I or Att s after de I Direct	Certification:	2 Accident 3 Suicide	6 Coul	d flot be	of Injury - A	t home, far	m, street, fac	tory, office	building, etc	28	f. Location (or Town,		d Number	or Rura	I Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Foneral Director:		4 Homicide 29a. Certifier (Check only		ysician: To the best	of my know	ledge, deat	h occurred at	the time, d	late and pla	ce, and due	e to the cau	se(s) and	manner a	s stated	25
			Medical Exa	miner:On the basis o and manner st	f examinatio			n my opinior	n, death occ			and plac	e, and due	to the	cause(s)
2-PEND		L	h.). ~	>			29c. Licens O.C.					ate signed ary 11,	•	h, Day, Year)
	-			who completed cause							_				
Sta	ite	Ling Li, MD 31. Date filed (Mont		nt Medical Exam	niner 90 gistrar's Sign		itimore St	reet, Bal	timore, N	/ID 2122	3				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9° 2011 ear January A M 0816 Peddicord Katherine C. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Marriottsville 11436 Old Frederick Rd. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min Auq 16 Day 213-09-6048 93 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material any injury or other traumatic event, the Medical Examiner must he material. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Marriottsville MD Howard 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21104 LISA 11436 Old Frederick Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian . Was Decedent Ever Armed Forces? 1 ☐ Yes 2♣ No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wool Mill Reweaver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rhoda Barker John Kenzie Willingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granddaughter 11436 Old Frederick Rd. Marriottsville, MD 21104 Kelly Haire 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Ardent Cremation Ser. 1/11/11 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilitarry H. Witzke's Family F.H. Inc. of Euneral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 23a. Paker. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Stoke **Physician** disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician the defendence of the design of th Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed?/ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗆 No 1 🗌 Yes ြု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [29b. Signature and til 29d. Date signed (Month, Day, Year, D0059184

State Registrar 30. Name and address

31. Date filed (Month)

of person who completed cause of death (Item 23a) (Type, Print)

5 5

. Registrar's Signature

1-10-11

Baltimere mp 2122

11-00150 Sandra Piper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sandra Piper		1- For State Registrar	SI	ate of Maryla		rtificate o		iu ivientai	70	2011	01908	
Physici Medical Exam		1. Decedent's Nan Sandra		e,Last)					2. Date of Dea Month January 5		3. Time of Death 0845 hrs	
		4a. Facility Name 509 Bay St	1111	n, give street and nu	mber)		4b. City, Town, o	or Location of De	eath	4c. County of Dea Worcester	th	
Funeral Director	1	5. Social Security 215-72-3	Number	6. Sex 1 M 2 X F	7. Age (In yrs. I	ast birthday) Yrs	If Under 1 Ye		Min.	rth(MM/DD/YYYY) 9. B		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed			2X No	If Y	Yes 2 X Nutsus Usual Occupa	n, Mexican, Pue		White, etc.	rican Indian, Black, Erican— American	
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Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		4 Donation 5	Cremation Other Sp		om State	crematory or oth	ition (Name of co nerplace) S Cemete		Date 15/2011	20c. Location - City o		
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Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit		IF FEMALE: 23b. Was decedent past 12 month	pregnant in th	1 Live bi	ant at time of de	2 Fe	tal death 3 ner (Specify)	Ectopic preg	gnancy	23d. Date of deliver Month	y Day Year	
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To the Hospita within 24 hours To the Funeral completely fille	Medical	(Check only one) 2 2	Medical Exar	niner:On the basis o and manner st	f examination ar			n, death occurre		e(s) and manner as star and place, and due to the 29d. Date signed (Mo	ne cause(s)	
Jan		ill	1	who completed eaus	e of death (Item	23a)	O.C.			January 6, 2011	,,,,	
γ' V st	ate	Russell Ale	th, Day, Year)	32. K e	edical Exam			Street, Balt	imore, MD 212	223		
Regist			AN 12	2011 72	and . A	1. Sar	Ken			DOME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Michael Parks 49 2411 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death RM IONAC SAUSBUL HICOMICA al Security Number If Under 1 Year If Under 24 Mrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Months Hours 1273071949 429-96-1121 61 Director Arkansas Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Examiner must be Funeral 23a 4725 Cardinal Drive 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 X No If Yes, Give "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after white 1 Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the plumber/pipefitter HVAC and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bobbie L. Parks Betty Miller Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print)
Susan Parks/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4725 Cardinal Dr., Salisbury, MD 21804 item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial 4 Donation 5 Other (Specify) 1/14/2011 Salisbury, MD 21. Signature of Funeral Service Licens ²² Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA -Physician/ ARDIAC VENTRICULAR disease or condition resulting in death) TIBRILLATO Medical Due to (or as a consequence of) Examiner ARREST ARDIO PUL MONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed the burial-transi YPERTEN that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IABE TES MELGI TUS Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the a d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director 2 X No ည 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 🖊 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 13864 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1325 HER MON AUZI Mil M) 31. Date filed (Month Pay 32 Registrar's Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23 are of Maryland, Department of Leady and Mental Hygiene 1. Decedent's Name (First. Middle, Last) 2. Date of Death Month Physician/ 2011 Martin Edward Simson 07 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Montgomery Derwood 16304 Jousting Terrace If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Days JAN 29 California 1968 **Director** 560-98-6369 42 Yrs Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County with the Maryland Director 1 Yes 2 No Derwood MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20855 16304 Jousting Terrace be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) American Express Financial Advisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Geradine Francoise Kokxhoorn Manfred Edward Simson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3747 Effingham Pl., Los Angeles, CA 90027 G.F. Simson / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 01/08/2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serice Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. M00956 Park Avenue, Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Asphyxia set and D Immediate Cause (Final Ph_sician/ Medical Examiner resulting in death) Inhalation of Automobile Exhaust Fumes Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examiner Due to for as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 Pregnant rate has been signed by the a page 2 should be detached to g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗓 No this certificate Yes 1 Tes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 4 \sum Nursing Home 5 Residence 6 \sum Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To funeral Manner of Death 28b. Time of 28d Describe how injury occurred Subject inhaled automobile cathering the subject inhaled automobile cathering and subject inhaled automobile cathering and subject in the 28a. Date of injury 28c. Injury at Found: 1/4/2011 Found: 4:00 1 Natural 5 Pending n 24 hours after death.

1e Funeral Director: Af holeted filled in by the fu 2 No Investigation Accident Jan 4 2011 28f. Location (Street and Number or Rural Route Number, City or Town, State) 630 4 30 5 7 75 KM 3 Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Garage Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2. nly one) 29c. License number 29d. Date signed (Month, Day, Year) ature and title of certifie 29b. Sid 00 2710 OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

Registrar

State

31. Date filed (Month, Day, Year)

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32: Registrar's Signature

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•	Examin		,		give street and number) ical Center			1		Location	of Death		4	c. County of Dea		
	Funeral Director		5. Social Security No. 218–24–8.		5. Sex 1 🔀 M 2 □ F	ge (In yrs. la 85	ast <i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi	rth ay, Year	9. B	irthplace (State or Foreign	
, A		ŗ	Usual Residence of 10a. State	10b. County			y, Town or L								10d. Inside City Limits	_
	e Maryla r 28a-f s notified	Direct (MD 10e. Street and Num	Allega	any 	F	Rawlin		0.4						1 🗆 Yes 2 🖾 No)
	s 23a or nust be	Funeral Director			Highway			10f. Zip	215	57		_		Citizen of What Conited St		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	==	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?	5. 13.	Was Deced If Yes, spec 1 Yes				cify Yes or No- Rican, etc.)	-	14. Race - Am Black, Whi		
Baltimore, Maryland 21215-0036	/ithin 72 hou iene. r than "natu the Medica	Completed	(Specification) (Specification		s Education grade completed) College (1-4 or	5+)	(Give	edent's Usua kind of wor DO NOT use in sto	rk done o retired)	during mos		_	1	Kind of Business er Manu	s Industry facturer	16
and 2	be filed w ental Hyg ked othe c event,	To Be	17. Father's Name (F		Salesky SF					18. Moth	ner's Name Audre	(First, Middle	,	n Surname)		
Mary	d 2 should alth and Me 1 27 is mar er traumati		19a. Informant's Na Elsie Sa											or Town, State, Z Maryla	ip Code) nd 21557	_
more,	Page 1 and nent of Her int: If item iry or othe				B ☐ Removal from State	_ C	Place of Disp emetery, cre	matory or o	ther place	re)		oate 7/2011		Location - City o	r Town, State t Maryland	
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	ed	Examiner	Sequentially list con it any, leading to im- cause. Enter Under Cause (Disease or i	imediate rlying	b. Due to (or as	a consequ	uence ot):									
30	be executed sician and burial-transit		that initiated events resulting in death) L		c. Due to (or as	s a consequ	uence of):	<u>-</u>								
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NE Is, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other signifi	icant condition	s contributing to death	but not res	ulting in the	underlying o	caus <u>e gi</u> v	en in Part	:1.				o the cause of death? Probably 4 Unknown	
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$\forall\mathcal{H}$ Division of	or Attendi after death Director: A d in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Place of In	ijury - At ho tc. (Specify	me, farm, st	M reet, factory		Yes 2		28f. Location (City or To			ural Route Number,	
サント	To the Hospital or within 24 hours after to the Funeral Direction completed filled in	Medical ((Check 2	☐ Medical Exa	hysician: To the best of aminer: On the basis of lurse Practioner: To the	examination	and/or inve	stigation, in r	my opinio	n, death o	ccurred at	the time, date	and plac	ce, and due to the	cause(s) and manner state	∍d.
, (To the within 2 To the comple	2	$\overline{}$	title of certifier	1/m	///		290)/s	370	69	, 435 10 11		Pate signed (Mon		_
		2	30. Name and addre	ess of person wh	no completed cause of	death (Item	23a) (Type,	Print)	Ze	500	DU	VILLE	W,	rszepol	TRI	_
~4	Stat	2 e	31. Date filed (Month	1 Day Year)	2011 32. Begist	rar's Signat	ure/	2RI	70,	W	171	BENL	A	40, M	10 2150	_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Michael Holt Seigel Medical 10:50 AM 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death • 546/5640 NICOMICO Social Security Number **Funeral** If Under 1 Year | If Under 24 Hrs Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth 1**X** M 2 □ F Days 216-78-2706 Hours (Month, Day, Year) 04/19/1974 Director 36 Yrs Marvland Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f Maryland Worcester Berlin 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1091 Ocean Parkway 21811 IISA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian. , or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" 3 Divorced Completed Specify white ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) it of Health and Mental Hygiene.

If item 27 is marked other that or other traumatic event, the N College (1-4 or 5+) 12 chef restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Allen Stewart Seigel Donna Gail Rasinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1091 Ocean Parkway, Berlin, MD 21811 Allen Seigel/father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/10/2011 Salisbury, MD permit. ²² Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any 4 arrò Homoson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Conbocarde Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day the hed t Year Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 2 No 1 Yes director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Certificate: To 1 🗌 Yes Other Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify, the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director; After 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation 1 🗌 Yeş 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) H0056197 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) 100

Registrar
DHMH 17 Rev 7/2009

State

144

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2011 14:03 PM BETTY LEE SPANGLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CECIL ELKTON UNION HOSPITAL OF CECIL COUNTY g. Birthplace (State or Foreign CountriCOLORA MARYLAND Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 XF Months Days Hours Min (Month, Day, Director 231-94-3102 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Director be notified ELKTON 1 Yes 2 No MARYLAND CECIL 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with must UNITED STATES 24 CHESTNUT DRIVE 21921 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Ex. miner Black, White, etc. 0 þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3√Widowed 4 □ Divorced "natural", Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. OWN HOME HOMEMAKER the ulth and Mental Hygie 27 is marked other r traumatic event, th other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ELLEN HICKMAN LEONARD BARROW t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 CHESTNUT DRIVE, ELKTON, MARYLAND LINDA SUE HOLLADA / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 F 4 Constion 5 Other (Specify) COLORA, MARYLAND WEST NOTTINGHAM CEM. 22. Name and Address of Facility CROUCH FUNERAL HOME 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Memoura disease or condition 170 UM Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medica 26. Place of Death (heck only one) examiner? Other: 2 10 1 🗌 Yes patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20/11 mi cee px 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHH HSU MD State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Billv Rav Timney 4^{Pay}2011 Year 10:32 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WM Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Yean 28 1 🔀 M 2 🗆 F Months Days Hours 89 Maryland 220-10-1763 **Director** Usual Residence of Decedent f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Allegany 28a-f MD Barton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 23106 Royal Lane SW 21521 United States be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No WW 2
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 white 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) unknown Paper Manufacturer College (1-4 or 5+) machine operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 William Timney Della Fairgrieve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau William David Timney/son 23108 Royal Lane, Barton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Laurel Hill Cemetery 01/08/2011 Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7 Wa 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ schemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of imjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death signed by the a 4 Pregnant : 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 (cate has page 2 s this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural iniury work?
1 Yes 2 No 5 Pending thin 24 hours after death.

the Funeral Director; Ai
mpleted filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title 29d. Date signed (Month. Day, Year Ca des

Registrar

State

VA

Douglas

Lona Coning.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director:

Be

the

by

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury осситеd 27. Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Death

Year

29d. Date signed (Month, Day, Year)

January 19, 2011

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature ORIGINAL

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Annette Augustine Urian Month Medical 9:37.4M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DICOMRO 100 hake bu 186 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Director 018-26-3250 Hours Min. (Month, Day, Year) 0/01/1934 Massachusetts Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester Bishopville 1 Yes 2 X No 5 10e. Street and Number Funeral I 10g. Citizen of What Country? "natural", or items 23a 12229 Lois Street 21813 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 X No 14. Race - American Indian, þ 1 Never Married 2 K Married Black, White, etc. Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ed other than " event, the Med Elementary/Seconday (0-12) Health and Mental Hygiene. College (1-4 or 5+) administrative assistant financial services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Raymond Emory Molleur Germaine Ouellette other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12229 Lois St., Bishopville, MD 21813 George A. Urian/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/10/2011 Salisbury, MD Signature of Funeral Service Licenses Funeral H Hill Rd., Home Professional Association ., Salisbury, MD 21804 avid A. Chompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MAHANAN LUNG Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated see or injury) Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy ģ in the past 12 months? 5 Other (specify) 1 Yes 2 Month Day Year s been signed by the selection should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown has been 24a. Was an 24b. Were autopsy findings available page 2 autopsy prior to completion of cause of death? certificate perform Yes 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident 1 Yes 124 hours after death e Funeral Director: 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one) 3 To the within ? 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Huyson BOP SALISBUM 2 1802 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

JAN 1 1 2011

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours after death To the Funeral Director; npletely filled in by the

Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopi	c pregnancy (specify)		Month Day Year
	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ed by	dementia,diabe	tes millitu	ıs		1 🗆 Yes	2 No 3 Probably 4 ₭ Unknown
Completed					24a. Was an autopsy performed?	
Be (25. Was case referred to medical examiner?				ath (Check only one)	
으	1 ☐ Yes 2 🔀 No	lospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
4.4	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		tory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Medical (red at the time, date and plaction, in my opinion, death occ		s) and manner as stated. nd place, and due to the cause(s)
ž	29b. Signature and title of certifier			29c. License number	29d. D	ate signed (Month, Day, Year)

D31319

8218 Wisconsin Ave. Suite 305 Bethesda, Md20814

January 4,2011

State Registrar Loreto Albiol

31. Date filed (Month, Day, Year)

M.D.

32 Registrar's Signature

ath (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Physician/ Month -Jan 4:20 AM IECT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Mar Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Delaware 1**X** M 2 □ F Months Days Hours Min. th, Day, Year) 222-38-3606 Director 58 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director DE 1 Tes 2 No Sussex Laure1 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code 19956 23a 32140 Hastings Drive USA Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) P.O.S. Systems Owner/Operator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barbara Ward Thomas Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Whaley (wife) 32140 Hastings Dr. Laurel, De. 19956 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o once. 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Cremation 1-10-2011 Millsboro, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Laurel, De. 19956 Hannigan, Short, Disharoon F.H. 700 West St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Intravera Physician/ disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Arteriovers Sequentially list conditions, it any, is admy to immediate cause. Enter Underlying Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending Μ 1 Tes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2011 and address of person who completed cause of death (Item 23a) (Type, Print) South Green 2120 22 31. Date filed (Month Aak) egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Hsien Min Yang 2011 January 12:00 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery National Lutheran Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Age (In yrs. last birthday) 1 **X**M 2 □ F Months Hours Min March 16, 1932 China **Director** 216-80-7422 78 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 9701 Viers Drive 20850 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Yang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Autumn Wind Way, Rockville, MD 20850 Steven Yang/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 10, Burial 2 Cremation 3 Removal from State Norbeck Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2011 Olney, Maryland . Signature of Funeral Service Licent 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 Yes 2 No 3 Probably 4 Unknown Discase 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No ☐ Yes Yes 25. Was case referred to predical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag

SANDEEP SHAMMA 743 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

29b. Signature and title of certifier en leep

> Sunne Walle Registrar's Signature

Medical

29a. Certifier (Check

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064624

Gatheston

20818

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifi	cate of	Death			Reg. No.	
Physici Medical Exam		Decedent's Name (First, Middle Andrew Nowell	· ·					2. Date of De Month	ath Day Yea	3. Time of Death 0645 hrs
		4a. Facility Name (if not institution			41	o. City, Town,	or Location	January of Death	25, 2011 4c. County	
1		Union Hospital of Ced	cil County			Elkton			Cecil	
Funeral		5. Social Security Number		In yrs. last b	oirthday)	If Under 1 Ye			irth (MM/DD/YYYY	9. Birthplace (State or Foreign
Director		169-70-4386	1 ∕ M 2 F		35 Yrs.	WOTUS	ays Hours		14, 1975	Country Mary 2 and
any		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Tow	n or Location	n				10d. Inside City Limits
*	<u> </u>	Maryland Cec	:11	No	rtheas	t.				1 Yes 2XXNo
Maryla 28a-f 1 at or	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of Wh	nat Country?
0036 within 72 hours after death with the Maryland gine. ger than "oatural", or items 23a or 28a-f abov Medical Examicer must be notified at once.	Ö	104 Ontario Co	urt			2	1901		United Of Ame	d States erica
S death wit or items 2	Funeral	11. Marital Status 1 XXNever Married 2 M	12. Was Decedent Event Armed Forces?	er in U.S.	13. Was	Decedent of H	lispanic Orig	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Race White	- American Indian, Black,
ter de			1 Yes XX	No		es 2XX N			i	White
ours at	d by	15. Decedent's Education (Spe	or Dates:	eted) 16a	. Decedent's	Usual Occup	ation (Give	kind of work done	16b. Kind of Bu	
16 n 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mos	t of working lif	e. DO NOT	use retired)		
within giene.	E	12th 17. Father's Name (First, Middle,	l oot)		В	rick L				onstruction
tal Hy	BeC	Andrew Nowell	,					's Name (First, Middle,	,	
MD 21215-0036 3 2 should be filed within 7 th and Mental Hygene. a 27 is marked other than umaric eveot, the <u>Medica</u>	2	19a. Informant's Name/Relations	·	1:	9b. Mailing A	ddress (Stre	et and Num	thryn Regin	mber, City or Town	n, State, Zip Code)
MD nd 2 sho alth and m 27 is		Andrew N. Abel	, Sr. (Father)		.04 On	tario (Court	, Northeast		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "eastural", injury or other traumatic evect, the Medical Examiner.		20a. Method of Disposition 1 XXBurial 2 Cremation	3 Removal from State	20b. Place	of Disposition	on (Name of co	emetery,	Jan. 30,		City or Town, State
Baltimore, permit. Pages 1 a Department of He important: If ite ujury or other tr		4 Donation 5 Other Sp 21 Signature of Spar Service	ecify:	Churc	h Ceme	etery		2011	Woodsto	ck, Maryland
Balt permit. Departi		21 Signature of the stall service	the contraction		11160	ne and Addres	s of Facility	Eckhardt I	uneral (Chapel, P.A. ills, MD 21117
Physician		2 is Fart. Enter the disease, or	comain tions that caused the	death. Do r	not enter the	mode of dying	, such as ca	ardiac or respiratory an	rest, shock, or hea	rt Approximate Interval
Medical Maminer		Immediate Cause (Final disease	on each line. a. Cocaine I	ntoxi	cation	ı				Between Onset and Death
		or condition resulting in death)	Due to (or as a conseque	ence of):						
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conseque	neo of):						
outed nd ransit	Ä	events resulting in death) Last	d.	arice or).						
760, ficate be executed g physician and the burial - transit	edical	X UNPENDED	AMENDED 23a,	27,28	a-f pe	r me g	913 3	-9-11 vt 1	as note	d
3760, ificate be g physici s the buri	₹Ι,	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome o						23d. Date of c	
Box 68' death certifi he attending d for use as 1	icia	past 12 months?	4 Pregnant at time	af death	2 Fetal 5 Other	death 3 (Specify)	Ectobic	pregnancy	Month	Day Year
be dea	Physician		nown 9 Unknown							
P. C	ā	Part II. Other significant condition	ons contributing to death but	t not resultin	ig in the und	erlying cause	given in Par	t I. 23e. Did to		pute to the cause of death? Probably 4 Unknown
ords, w require s been sig	Completed							[24a. Was		ere autopsy findings available
e law e has t	Ē								rmed? de	ior to completion of cause of eath?
tal Recision: The certificate		25. Was case referred to medical				26 Place	e of Death (1 ✓ Yes Check only one)	2 No 1	Yes 2 No
Vital I bysiciao: this certifi	To Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/0	utpatient 3		Othor -	Nursing Home 5	Residence 6	Other:
liog Pl		27. Manner of Death 1 Natural 5 Dead	28a. Date of Injury (Month, Day,Year)	28b.	Time of Injur		ry at Work?	1	now injury occurred	d
SiOr Atteo death ector:	läti	Pendi	igation Id I-25-1		6:20a	m	Yes 2 🗶	UHKHOW		
Division of pital or Atteodog Phous after death over albrector: After the filled in by the funeral filled in by the funer	린	3 Suicide 6 X Could 4 Homicide determ	not be not be (Specify)		arm, street, fa idence	-	ouilding, etc	or Town, S	tate) 104 N.	or Rural Route Number, City Ontario Ct.
Hospi 24 hou Fuoer tely fil		On Cortifies	ysician: To the best of my kno				ate and place		East, Md.	
To the Hospi within 24 hou To the Fuoer		one) 2 Medical Exam	iner: On the basis of examinat and manner stated.	tion and/or i	nvestigation,	in my opinion	, death occ	urred at the time, date	and place, and du	e to the cause(s)
	Σ	9b. Signature and title of certifier				29c. Licens			29d. Date signed	(Month, Day, Year)
•		Yumle / Vous	Theul. ML)			0.C.I	M.E.		January 25,	2011
1	13	0. Name and address of person v Pamela E. Southall, MI	· · · · · · · · · · · · · · · · · · ·	,,	r 900 W	/. Baltimore	e Street	Baltimore, MD 2	1223	
Sta	te 3	1. Date filed (Month, Day, Year)	32. Kegistrar's Si							
Registr	ar	JAN 312	011 Senson	A.,	porte					
DHMH 17 Rev 1/200	01	120		OR	IGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Philip Douglas Anderson 01 ,48 Medical 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth ^{g. Birthplace (State or Foreign} Country) NOTTN Carolina Oct. 16, 1926 242-36-8015 Months Days Hours Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number r items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 6404 Sefton Avenue 21214 U.S.A. be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian ō 1 Never Married 2 Married Black, White, etc þ Baltimore, Maryland 21215-0036 Specify: White "natural", 1 ☐ Yes 2 X No Specify: 44-147 Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Industry Electrician traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Leroy Anderson Sarah Victoria Owen 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Daniel Anderson Woodpecker Lane, Saluda, North Carolina 2877 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Infortant: If ite any injury or ot 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PolkMemorialGardens 1-29-11Columbus, NorthCar. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A michael Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fliysician/ disease or condition ocardia Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has page 2 perform 2 🗆 No funeral director, 25. Was case referred to medical Be B 26. Place of Death (Check only one) Hospital Certificate: To 1 🗌 Yes 2 No Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the I within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print NEHA KALARIA E UNIVERSITY PROJE 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Gary B Brooks 25 January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 2228 W. BALTIMORE ST. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye Months Days Hours 1 🛛 M 2 🗆 F Yrs Director 212-56-8146 Usual Residence of Decedent or 28a-f shov **Funeral Director** 10a, State 10b. County 10c. City, Town or Location the Maryland Examiner must be notified at N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once. 2228 W. BALTIMORE ST. 21223 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: BLACK 3 🗌 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) -12-LABORER WAREHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BERNARD BROOKS MARY SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2228 W. BALTIMORE ST. BALTIMORE, MARYLAND 21223 MINETTE BROOKS (WIFE) 20a. Method of Disposition 1 Burial 2 Cren 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2
Crem tion 3 🗌 Removal from State 4 ☐ Donation 5 ☐ other (Specify) TRINITY CEMETERY 2-1-2011 BALTIMORE, MARYLAND D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL 21. Signature of Fundral Ser vice Lice ise JONATHAN. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Immed a → Cause (Final diseas ← condition resulting in death) Prostate cancer Ph_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or higher) Examiner Due to (or as a consequence of) and that initiated event Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this I filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

N5 Ray apanu M·D

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ¥ Yes 2 □ No

MARYLAND

HOME, P.A.

Dav

2 No

1 Yes

29d. Date signed (Month, Day, Year)

1127/11

00057465

Year

Approximate Interval Between Onset and Death

1:19 AM

Year

State Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) JAN 3 1 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ax 5- Z03- Balh more, MO. 2120 5 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Physician/ Month Samuer 2°C 10:10 A M Charles Marvous Bailev Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death 12 Mic 6 If Under 24 Hrs. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, 6/6/193 **Funeral** 9. Birthplace (State or Foreign WXM 2 I F Months Days Min. VA Country) Director 226-46-0140 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1016 Minnetonka Road 21144 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Maintenance Inspector</u> US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Everett Bailey Alvonia Herron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra Bailey 1016 Minnetonka Road Severn, Md 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Hill Cemetery 2/3/2011 Brooklyn, MD21225 Signatur Funeral Se 22. Name and Address of FacilitySingletonFuneral& Cremation Services PA 1 2nd Ave SW Glen Burnie, Md 21060 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician. Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 X No Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Ves 2 1 No I 🗌 Yes 1 Yes 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes |2 1 Inpatient 2 - ER/Outpatient 3 - DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certif 29d, Date signed (Month, Day, Year)8 2011 tom con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Ó 830 Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UCMC HARFORI) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 **M**M 2 □ F Months Days 69 Hours Min. 05-26-194 Director 213-40-0308 Yre MD Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Havre de Grace 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 843 Tydings Rd Apt A 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 Ty Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Man Sears is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Buck Healy Onnie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Deborah Bransky (wife) 843 Tydings Rd Apt A Havre de Grace MD 21078 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01-22-2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility of Facility
Schimunek Funeral Home of BelAir
MacPhail Rd BelAir, MD 21014 any 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ ACUTE CIRCULATORY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner IMMUNO (OMPROMISED 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 🗆 No page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL TRANSPLANT 1 Yes 2 No 3 Probably 4 Unknown peen : CARDIO My OPATHO 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate 1 Yes Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 2 No Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Natural 2 \(\text{\backsquare} \) 28b. Time of 28d. Describe how injury occurred 5 Pending injury s after death 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mp D66342 120 | 11 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) 500 1062 BEL- AIR CHESADEAKE 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signati State JAN Registrar DHMH 17 Rev 7/2009

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2011

JAN31

29c. License number

D0063974

TOWSON. MARYLAND

29d. Date signed (Month, Day, Year) 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JESSIE BROWN** Month -0 M Medical DII 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5406 15M8 to Funeral 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 250-03-1443 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Year) Director 99 NOV. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medic A Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1

Yes 2 □ No MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 5406 CRISMER AVENUE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 █ No
If Yes, Give ģ 1 Never Married 2 Married Black, White, etc. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCE RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 🕠 🗸 🗠 ျှ HARRY **BROWN** ALMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA BROWN/DAUGHTER 5406 CRISMER AVE., BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM 02/05/2011 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to cause. Enter Underlying Cause (Disease or iinjury that initiated events Directo for as a consecuence of Exami and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō 5 Other (specify) Pregnant at time of death Month Day signed by the a d be detached f Yes 212 No Year 1 ☐ Yes 2 2 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 ANO Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending injury hours after death. Accident Investigation 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ah WW 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	Tillicate of	Death	2. Date of De	Reg. No.	U I J G I
	Physici Medi		William Bell				Month	Day Year	3. Time of Death
4	Exami		4a. Facility Name (if not institution, give street and number)			or Location of Dea		4c. County of De	
***	<u></u>	P	Bon Secon VS 5. Social Security Number 6. Sex 17 Age 1		Baitn			Bautma	are Cuty
ı	Funeral Director		239-78-3793 6. Sex	In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days			th 9. B 26, 1945	irthplace (State or Foreign Sountry) North Carolir
	, MC		Usual Residence of Decedent				Dec	20, 1945	North Carolin
	Maryland 28a-f show otified at	Director	10a. State 10b. County	Oc. City, Town or Lo					10d. Inside City Limits
	or 282 notif	Dire	10e. Street and Number	Baltim					1 D Yes 2 □ No
	with ti 23a o sst be	Funeral	341 S. Mount Street		10f. Zip Code 212	23		10g. Citizen of What C	•
	leath items er mu	Fun	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. V			Specify Yes or No- to Rican, etc.)	14. Race - Am	
36	after (þ	1 Never Married 2 Married Armed Forces? 1 Yes 2 Nover Married If Yes, Give		f Yes, specify Cub		to Rican, etc.)	Black, Whi	
8	atura cal E	etec	3 Widowed 4 Divorced If Yes, Give Year or Dates.					Specify:	Black
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done O NOT use retired	during most of wo	orking	16b. Kind of Business	s Industry
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ž	should be file and Mental I is marked o raumatic eve		Eugene Bell 19a. Informant's Name/Relationship (Type, Print)	51		Anni			
	d 2 shall ar alth ar 27 is		John Bell, Jr. /Nephew	19b. Mailin 24	g Address (Street 02 Winch	and Number or R ester St	ural Route Number	; City or Town, State, Z	ip Code) e, MD 21223
ore,	ge 1 and 2 nt of Healt i: If item 2 or other 1		20a. Method of Disposition	20b. Place of Dispos	sition (Name of				
Baltimore,	permit. Page Department or Important: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place ake Crem	´ :	Date Jan 29 2011	' Beltsvil	lle, Maryland
3alt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee			1		ternatives	
ī	407 60	-	and here better.		8717 Gr	en Pastu	res Drive	Towson Mar	yland 21286
	Perminance		23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e death. Do not ente	r the mode of dyin	ig, such as cardia	or respiratory arre	est,	Approximate Interval Between
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0	icate be executed g physician and s the burial-transit	dical	resulting in death) Last Due to (or as a co	onsequence or):					
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Box 687	ath certifica attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the past 12 months? 1 □ Live Birth 2 □		Catania anno			23d. Date of de	livery
Bo	t the death by the att tached for	sici	in the past 12 months?		Ectopic pregnance Other (specify)	:y 		Month	Day Year
P.O.	nat the ed by t detach	F.	Part II. Other significant conditions contributing to death but r	ot resulting in the un	derlying cause civ	en in Part I	00 5:111		
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ord	v requ	Sete					24a. Was ar		topsy findings available
Division of Vital Records,	sician: The law certificate has t irector, page 2 s	Completed					autops perforr	y prior to oned? death?	completion of cause of
ā	sian: T	Be	25. Was case referred to medical examiner?		26. Pla	ace of Death (Che	1 🗆 Yes 2	2 ∑ Yes 1 ∐ Yes	2 2 10
⋛	Physic this o	၉		2 ER/Outpatient	3 🗆 DOA Othe	r: 4 □ Nursing ⊢	ome 5 Reside	nce 6 Other (Spec	ify)
0	ding th. After funer	Certificate:	27. Manner of Death 17 Natural 18 Dending 28a. Date of injury (Month, Day, Yes)	ar) 28b. Time of injury	28c. Injury work	?	28d. Describe ho	w injury occurred	
Sio	Atten ar dear ector: by the	≝	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	At home, farm, stree		Yes 2 No	28f Location (Sta	and Alumbar an Dur	
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	Hospi 4 hou Funer ted fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	knowledge, death oc	cured at the time,	date and place, a	nd due to the caus	e(s) and manner as sta	ted.
;	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 Certifying Nurse Practioner: To the best	of my knowledge, de	ath occurred at the	time, date and pla	ce, and due to the	cause(s) and manner as	stated.
	= ≥ 1 8		11 . 4	O .	29c. License			d. Date signed (Month	
	α		Marua Cout, ms - aller d. 30. Name and address of person who completed cause of death	(tem 23a) (Type, Prin	n 1003	6240]	Partimore	0 2011
	4		Marcia Cost, ms Bon Seway 1-	MOSPITZU O	600 W. 12	ia Itanom	Street 1	Baltoman	m 37383
	State		32. Registrar's S	Signature				- SCI I MONE	
	Registra		JAN 3 1 2011 Lanson B.	See all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 27,2011 Year 9:10 a^M David Scott Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 510 Towson Ave. Lutherville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₩M 2 □ F Months Days Hours Mary Tand 213-60-6908 58 Director Usual Residence of Decedent 28a-f show 10a. State iral", or items 23a or 28a-f shore Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Lutherville Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 510 Towson Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black White etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the James Posey Associates Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Rethschulte Freda Cicero H. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is rank injury or all 510 Towson Ave. Lutherville, Maryland 21093 Patricia A. Brown/Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp.:1/28/11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or desplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Glioblastoma Multiforme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy performed? Yes 2 No page death? this certificate 1 ☐ Yes 2 🗙 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\square\) Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State, 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatul 200640999 1/28 2011 ause death (Item 23a) (Type, Print) BALTIMORE, MA

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State

Registrar

address of person who complete BLAKELEY

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led (Month, Day, Year)

3 1 2011

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32 Begistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arbutus Xinvar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Boonsboro MD Washing Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 217-20-1590 Director Hours Min. March Day 2 ear 1925 85 Yrs Kansas Usual Residence of Decedent 28a-f show 10a. State Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11132 Mahogany Drive 21742 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. o, 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cannie L. Hollins 1 4 1 Lila Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Hull / Daughter 11132 Mahogany Drive Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/31/2011 Finksburg, Maryland Evergreen Memorial Park 21. Signature of Full III e Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. owson, Maryland 21204 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) ennent Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day 5 Other (specify) hed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate performed Yes 2 No 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 → Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? Accident Investigation 2 No 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifier Kate M. Smith, CRNP R128088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kate M. Smith Hagerstown, MD 1126 opal ct. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Timothy Bond January 201T Medical 12:20 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Sex 1X□ M 2 □ F 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. Feb. 18 Year 1939 Director 467-62-9481 Yrs Louisiana Usual Residence of Decedent 28a-f show 10b. County 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2 🙀 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 702 Seth Court 21286 USA or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Never Married 2 Married <u>Ş</u> 1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc. Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Completed white event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Systems Engineer Vitro Labs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ John Bond Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chrystelle T. Bond wife 702 Seth Court; Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Donation Specify) entonment Dulanev Valley Mem Gardens 1/29/2011 Timonium, 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to or as a consequence of): for it Examiner af ovene month 1 Sequentially list conditions, if any, leading to Immediate cause. Liner Underlying Cause (Disease or iinjury that initiated executions) Examine consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Vasular discust Deni bhera signed by the attending physician and a betached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work? in 24 hours area the Funeral Director: Af maleted filled in by the fi Accident Investigation 2 No Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur tle of certifier

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Lee Boyd 10°11 / 26 / 2011 06:30a_M Medical 4a. Facility Name (if not institution, give street and number) 5338 Wright Ave City, Town, or Location of Death Baltimore Examiner 4c. County of Death Baltimore . Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2 X F 148-28-5450 06727/2011 Director Usual Residence of Decedent 28a-f shov 10b. Count 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Baltimore 10d. Inside City Limits Director Baltimore MD 1 ☐ Yes X☐ No 10f. Zip Code 21205 10e. Street and Number 5338 Wright Ave ъ 10g. Citizen of What Country? 23a Funeral IISA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Homemaker (Specify only highest grade completed) and Mental Hygiene. is marked other than within Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Pierce permit. Page 1 and 2 should be file Department of Health and Mental . Important: If item 27 is marked c ary injury or other traumatic eve once. Joseph Brian 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3210 Meadow Valley Dr Abingdon MD 21009 Debra Hoffman Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1/29/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligense 22. Name and Address of Facility Simplicity Crem and Fun Ser Thomas Allen PA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
24 Lows Immediate Cause (Final Physician/ Supsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant a Year ed by the a detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Auxen M Cu D00 56156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles Street Ballimore

DHMH 17 Rev 7/2009

State Registrar Suzanne M.

31. Date filed (Month, Day, Year)

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accorned, un)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ dan Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Balto. Northwest Hospital Season's Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. Month, Day, July 14 Country)
Maryland 1 🗆 M 2 🗓 F Director 216-12-6591 88 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 X No Balto. Parkville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10114 Tipperary Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic evence. ည Oscar Wurzbacher Bessie Link 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hieber DTR. 4318 Falls Park Road Perry Hall, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1-25-2011 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Signature of Fune Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of The law requires that the death certificate be executed trans and that initiated events resulting in death) Last Due to (or as a consequence of): physician al s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 5 Other (specify) Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Yes Yes 2 X within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier raddress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 31

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Registrar
DHMH 17 Rev 7/2009

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			For State	State of M	laryland	/ Depa		t of H	ealth a		lental Hy	- (3	der semin	01933
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Juneral Service L	igengee			. Name an	d Addres	s of Facilit	Bra	dley-	Asht	on	Fune	ral Home
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Division of Vital Records,	al or safter		4 - Hornicide determ	building, et	tc. (Specify)						City or Tow	n, State)			
_	Hospital or Attending Physician: The law requires that the death certificate 44 hours after death. Funeral Director: After this certificate has been signed by the attending physted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best o	of my knowledg	ge, death o	occured at	the time,	date and p	olace, and	d due to the ca	use(s) and	d manne	er as stated	I. se(s) and manner stated
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Me	only one) 3 Certifying	Nurse Practioner: To the	e best of my kn	owledge, o	leath occur	red at the	time, date	and plac	e, and due to th	e cause(s)	and ma	anner as sta	ted.
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Ų			30. Name and address of person	word W	doath (Itam 00	a) (Time T	Print)	7 10	471			Jan	uan	125	2011
5			30. Name and address of person	Who completed cause of the H940 East	Stran A	re f	wilde	10 R	Pany	n 23	55 Pm	Him a	re.	Cim	2011 2011 21224
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	Registr		JAN 3 1 2011	Buena DA	bau	Ked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gerald Joseph Clark, Jr. 8:06 a M 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore <u>Towson</u> Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. 6/22/1970 MaryTand 40 218-80-6294 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Harford Bel Air 1 🗆 Yes 2 🗶 No Maryland 10f. Zip Code 21014 10e. Street and Number ò 10g. Citizen of What Country? ms 23a or must be r Funeral 904 Hackberry Court U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married þ ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.
27 is marked other than "r raumatic event, the Med life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accountanting Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Barbara Keene Gerald Joseph Clark, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 s tment of Health a tant; If item 27 i jury or other tra 904 Hackberry Court Bel Air, Maryland 21014 Christina Clark / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery: 2/2/2011 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 6 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Due to (or as consequence of): veuvs disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to for as a consequence of that y hading to him of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death detached g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Who 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 1 Yes 2 No 1 Yes 2 16 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 10 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: atural injury 5 Pending 1 Yes 2 No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 24 hours a Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I To the 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 4105 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:44 AM ROBERT **EDWARD** CREAGHAN 201 O I Ic. County of Death /Medical 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) Examiner altmore Hospital HLANES ltimore Year If Under 24 Hrs. 8. Date of Birth 05/13/1921 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral X1**√ M 2□ F Days Hours Country) Maryland Months 218-12-8433 89 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XX yes 2 □ No Director Maryland None Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3300 Benson Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ₩XXes 2 □ NoWW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 ″1 □Yes XIX No Specify Specify: ⋧ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Nursery 2 should be filed wing and Mental Hygier is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augustin Creaghan Lorretta Flannery 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 132 Clarendon Avenue Baltimore, Maryland 21208 Carol A Mantz Department of Health Important; If item 27 any Injury or other treatment. Dtr 20a. Method of Disposition 1 Durial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 3 Removal from State St Charles Cemetery 02/01/2011 Pikesville, Maryland 4 Donation 5 □ Other (Specify) 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc ature of Funeral Se 6500 York Road Baltimore, Maryland 21212 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as in each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or shock, or heart failure. List complication Immediate Cause (Final Physician Neumonia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner apric severe Due to (or as a consequence of) burial-Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.O. q | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 □ No Vital funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖼 🗖 🗖 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ð 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ebreweld, Mis. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u> Date filed (Month, Day, Year)

JAN 31

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Danuary liam Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Home 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** . 1<u>930</u> 1**X** M 2 □ F Months Min. (Month, Day, South Carolina Sep. 80 Director 250-38-9899 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 No Florida Harford Port Orange 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 32128 2917 Cypress Ridge Trail 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examira 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Lieutenant Colonel U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Caroline White William Dana Crosland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Cypress Ridge Trail, Port Orange, FL 32128 Margaret L. Crosland / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-25-11 Hilltop Service Corp! Twoson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deatl Immediate Cause (Final Physician/ monde monary disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Year Pregnant at time of death 9 I Inknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Regunsitation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Mbn ya Yes 2 **X**Vic Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **N**No 1 Yes Other: ည 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Vatural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

6

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CARDILLO 6:18 PM Menny 17 JAY 7211 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL CURUMBIA HOWARD INDSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 1 XM 2 □ F 79 Director 067-26-0715 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f shoner must be notified at Director Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4301 Brittany Drive 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. o 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Self Employed <u>Attorney at Law</u> if Health and Mental Hygi item 27 is marked other other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic e Frank Cardillo Ruth McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Brittany Dr. Ellicott City, MD 21043 Christine Cardillo - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 2/4/11 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 22. Name and Address of FacilitHarry H. Witzke's Family F.H. Inc 21. Signal re Funeral Service Lice M00845 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ACUTE RESPIRATIONY 3 WEEK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 4 WEEKS PNEDIMONIA BARTERIA Sequentially list conditions, Examiner Due to for as a consecuence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC PRSTRUCTIVE PULMONANY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE INSTANT 24a. Was an After this certificate has performed 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D36974 JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 CHARTOR DRIVE Counsia mo 2,544 NWO MOTUMYN. O 31. Date filed (Month, Day, Year, 32. Registrar's Sanature JAN31 201 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #4acba16b Per Phy 5th G921 2/18/2011 H State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 01-27-20 Pay Year Mary M. Dabrowski 0100 A M Medical 4a. Facility Name (if not in the property and number) Examiner 4b. City, Townart Cation of Vatle 4c. County of Death Hartord Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
 MD 1 □ M 2 😾 F Months Davs Hours Min. 03-04-1946 212-42-5902 64 Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at Director 10c. City, Town or Location 10d. Inside City Limits notified MD Harford 1 ☐ Yes 2 X No Jarrettsville 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 3205 Zieglers Ct 21084 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other terms. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced Specify:USA Year or Dates 16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Dunbar 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip Kron Alma Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Macintire (Dtr) Luna Lane Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Bayview Crematory 01-31-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FibriTlation Ventricular Physician/ Probable disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner orang Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day 1 ☐ Yes ∠ ₪ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 □ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W sevin4 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01°7'27/2011 8:00 a Dubiel Ruth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Abingdon 41 Boxthorn Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Days Hours Min. May 22, 1932 223-36-8398 78 VA Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 1 Yes XXX Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral USA 21009 41 Boxthorn Road 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Narried 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed to Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Amos Shakleford Vivian E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Boxthorn Road, Abingdon, MD John P. Dubiel, Jr. (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State 01/29/11 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home, Bel Air 21. Sign ture of Funeral Service Licen 22. Name and Address of Facility 21014 610 W. MacPhail Road, Bel Air, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ and disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 only one Name and address of person who completed cause of death (Item 23a) (Type Sint) Run DD, Ballo Utem mers 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

C.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registr*a*r Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day PM 9:16 Devaneu 2011 Januara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview medical center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. 9-8-1941 Country) 69 219-38-9960 MD Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location ä death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified MD 1 Yes 2 No Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1004 Evans Way 21205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. , or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 9 <u>Welding Engineer</u> Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Anna Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Devaney - Wife 1004 Evans Way, Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Himportant: If ite any injury or of once. cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Atlantic Crematory 2-1-11 Glen Burnie, 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licensee Bradley-Ashton Funeral Home Dethad llow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AAA disease or condition resulting in death) Ruptured a hours Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? Yes 2 No certificate 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work? 1 ☐ Yes 2 ☐ No injury 1 Natural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, Af completed filled in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES - 000 29,2011 2 0 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Camp Baltimore MD melissa mn 4940 51934 Eastern 31. Date filed (Month, Day, Yea. JAN 3 1 2011 32. Registrar's Signature State arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27,2011 4:30P M Charles J. Druery, Jr. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6600 Detroit Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MPyntry) 1 🛛 M 2 🗆 F Months Days Hours Min. 216-32-7000 73 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21222 USA 6600 Detroit Avenue death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Map Maker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sophie Meling Charles J. Druery, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6600 Detroit Avenue, Baltimore, MD 21222 Marlene Kraemer - Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1-29-11 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory . Signature of Funeral Servi 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due or as a construence of: Examiner reus Sequentially liet conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequ attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate 2 🗌 No 1 🗆 Yes 1 🗌 Yes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Watural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of ce Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 filed (Month, Day, Year . Registrar's Signature 32 State JAN 31 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph A. Drucker AKA Aaron J. Month Drucker Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ent Himore 0 ra eda 8. Date of Birth (Month, Day, Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 1 M 2 D F Days Year) Director 90 088-12-2844 New York Usual Residence of Decedent 10a. State 28a-f shov 10h County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Baltimore Middle River ō 10e. Street and Number Medical Examiner must be 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 510 Cole Lane 21220 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married ō þ Black, White, etc. 1 Yes 2 No りらいらととううらSe Baltimore, Maryland 21215-003 "natural", Completed 3 Widowed 4 Divorced 1 Yes 2 No Specify: Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chilton Books Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Page 1 and 2 should be ment of Health and Menta William Drucker Kate Tulchinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Erma L. Drucker /Wife 510 Cole Lane Middle River, MD 21220 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Scremation 3 Removal from State cemetery, crematory or other place Jan 29 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 permit. 21, Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives Malyyz Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) ra Medical Due to (or as a consequence of) Examiner DOY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed 07/6 that initiated events as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? 2 No Month Day Year the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed?/ Yes 2 No this certificate monas To the Hospital or Attending Physician: director, 25. Was case referred to me Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes မ Other: 2 ER/Outpatient 3 DO/ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Mann of Death Certificate: 28a. Date of injury 28b. Time of eral Director: After ifilled in by the funera 28c. Injury at 28d. Describe how injury occurred 1 V Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mi PXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Sak 9000 wuscu MD Fra 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Box 68760 P.O. of Vital Records,

Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completed filled in by t	
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Sta Registra	ì
DHMH 17 Rev 7/20)(

1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 5. Social Security Number **Funeral** Director 213-38-5673 Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f sho must be notified at Director 10e. Street and Number Funeral an "natural", or items Medical Examiner mu ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Completed 3 Widowed 4 Divorced Should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) the Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 1 and 2 sof Health item 27 other tra Stanley R. Gambrill/Nephew 20a. Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or of 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or corpolications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 Yes 2 ģ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ The law requires Completed has page 2 certificate ending Physician: 25. Was case referred to medical Be 1 X Yes ျှ 27. Manner of Death Certificate: After 1 🗖 Natural eath. 2 Accident
3 Suicide Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 28 2011 D67248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRETCHEN DICKINSON. M.D. 7601 OSLER DRIVE TOWSON. MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 31 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Clara Alberta Duncan 20 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner County of Death grane n yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√ F Months Days Hours Min (Month, Day, 88 213-16-0295 Director Iune <u>Pennsylvania</u> Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City. Town or Location aţ 10d. Inside City Limits Director items 23a or 28a-f s er must be notified 1 Tes 2 No Marvland Baltimore Rosedale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1315 Chesaco Avenue, Apt. 214 21237 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3X□ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, the of Health and Mental Hygien filem 27 is marked other th) UNCAN, (Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie May Sherman Marion F. Newlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth E. menefee/Niece Stockwell Road, Parkville, Maryland21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot. 1 X Burial 2 Cremation 3 Removal from State GardensofFaith 1-28-11 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. I 21. Signature of Funeral Service Licenses 6009 Harford Road,Baltimore,Maryland21214 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) monary Medical Examiner nacstive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ŏ Day Month Year Pregnant at time of death ate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 🗆 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Getting Prijstican: to the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and mainle as stated.

2 Getting Prijstican: to the basis of examination and/or investigation, in my opinion, death place, and the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1/24/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore My, 21237 9000 Frankl State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Donald F. Engel, Sr. January 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Manor Care Catonsville Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral (Month, Day, Yea 75 Yrs. Months Days Hours 1 X M 2 □ F Illinois 1936 Director Jan. 359-26-2047 Usual Residence of Decedent 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 271s marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 1218 North Ave. 21227 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No 1954-Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed 1958 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) tool maker 12 Westinghouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorine Zingerman Frederick J. Engel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 North Ave. Baltimore, Maryland 21227 Marcella S. Engel / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory,LLGFeb. 1,2011|Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Signature of Funeral Service License 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Obstructive Pulmona nonic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiovascular Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Barks

CENTER DRIVE

RSTOWN, MO 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 20 Î January 10:35P M Lee Fairchild Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 549 Jandon Court Millersville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 ፟M 2 □ F **Funeral** Country) Ohio Months Days Hours Aug. 15,1930 Director 80 286-24-5301 Lisual Residence of Decedent show 10a. State 10c. City, Town or Location with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Millersville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21108 549 Jandon Court should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural" or thans Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. Ď 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Warrant Officer United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irene Martin Loraine Fairchild Marjorie Robert permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 549 Jandon Court Millersville, MD Mrs. Lois C. Fairchild / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Feb. 1, 4 ☐ Donation 5 ☐ Other (Specify) MDVeterans Cemetery Crownsville, MD 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Sep Glen Burnie, MD Singleton Funeral & Cremation Services, PA M01/2/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (gnegl Physician 20 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Imjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate has 2 X NO 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\sum \) Other (Specify) 1 Tyes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural iniury 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Depth Marise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2. only one 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year)

10 X1

State Registrar 30. Name

Date filed (Month, Day,

2011

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DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jacqueline Elaine Eagle January 201T 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Dec. 19 Social Security Number 9. Birthplace (State or Foreign **Funeral** Year! Hours 228-28-6511 82 Director Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director MD Montgomery Silver Spring 1 Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 8505 Springvale Rd. 20910 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Examiner Armed Forces?, Black, White, etc. 5 2 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes Give White 'natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Trade Publications other other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) and Mental F is marked or ၉ Robert Eagle Eileen Guthridge permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Cathedral Ave. NW #19-B, Washington D.C. 20016 George Edward Eagle / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 1/25/2011 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last Pleural Effussion burial-tran Due to (or as a consequence of) Physician/Medical Coronary Artery Disease or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the nding p nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 XXNo for Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteomylitis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2XXNo page 2 s certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending nours after death.

neral Director: Aff Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0055856 January 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Rd., Silver Spring, MD Negash Ayele M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 3 1 DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Irma Elegant January 9:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Nursing Center Mitchellville Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** (Month, Day, Ye 1 □ M 2 😿 F Months Days Hours Min Year New York 98 Oct. 1912 Director 375-42-6422 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits at 10c. City. Town or Location Director notified Mitchellville 1 ☐ Yes 2 X No MD Prince George's 10f. Zip Code 10e Street and Number ō 10g. Citizen of What Country? items 23a or ner must be n Funeral 10450 Lottsford Rd. 20721 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Force Black, White, etc. 5 þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 72 hours after nan "natural", Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. Social Services life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the D.C. Government Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental H
Important: If item 27 is marked out
any injury or other traumatic even 0 Henry Bellick Sadie Sobo1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 First St. #102, Alexandria, Abby Owen / Daughter 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 1/25/2011 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of June of Service Licensee Name and Address of Facility app Funeral and Cremation Services Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerosis with Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** <10 Years Alzheimer's Disease Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Peripheral Vascular Disease <10 Years requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Advanced Age (98 years old) Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law has autopsy certificate ha performed? death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛛 No Other: 4 XNursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending nours after death.

neral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hin 24 hours a the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the comple only one and title of certif 29b. Signa 29d. Date signed (Month, Day, Year) D042049 January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Alain G. Champaloux M.D.

31. Date filed (Month, Day

JAN 3 1 2011

32. Registrar's S

14314 Old Marlboro Pike, Upper Marlboro, MD

20772

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P^{M} January 2011 Michael Fabian Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 207 Cedar Drive Anne Arundel Glen Burnie 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 🖾 M 2 🗆 F Hours March 19 1953 Country) 213-64-1605 57 Yrs. Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Cedar Drive 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married δ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinest Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Ε. Fabian Lawrine Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Fabian 207 Cedar Drive, (spouse) Glen Burnie, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date 01 cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Liga 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only of plications that cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No 1 Yes 2 I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown has been signed that the hand Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investi**g**ation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29c. License number D0064178 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 Hospital Drive, #312, Glen Bounie, Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 10:20 PM JANUARY 2011 Jane F. Fields /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine IT MOK ST, AGNES HOSPI NONE Date of Birth (Month, Day, Year) 12/20/1928 Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours Months 214-24-6860 1 □ M 2 🗓 F 82 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location to or 28a-f show 10a. State 10h County 10d. Inside City Limits 1 ☐ Yes 2 No MD Director Baltimore Catonsville 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 1904 Lismore Ln. 21228 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 No Specify ۵ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home marked other 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked ot traumatic ever Edward A. Branning Sr. Mary Catherine Connelly ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Anne Wills - Daughter 3109 Argent Path Ellicott City, MD 21042 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn 02-01-2011 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** 2 DAYS ACUTE ISCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by STENOSIS 2 No icate has been significate by page 2 should b 1 🗌 Yes 3 Probably 4 Unknown PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No OBSTRUCTIVE 24a. Was an autopsy performe this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ie Hospital or Attending Pl 24 hours after death. ie Funeral Director: After ti 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AVENUE 900 CATON KATHERINE KATSRIKU Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 95 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUAR-Physician/ UGENE 2011 1525 PM Medical 4a. Facility Name (if not institution, give street and num 4c. County of Death Examiner 4b. City, Town, or Location of Death HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 1 Year If Under 24 Hrs If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, August Months Hours 214-80-7633 52 Yrs. 19,1958 Maryland Director Usual Residence of Deceden or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director N/A Baltimore Md. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 267 South Elwood Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Motor 12 years 1 year Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Tagliaferro Theresa Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Millwright Circle, Abingdon Md. 21009 Sister Joyce Repko 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State Dundalk, Maryland Sacred Heart Of Jesus 4 Donation 5 Other (Specify) 28, 2011 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21. Signa ure of Fundral Service Licensee nplications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or Approximate shock, or heart failure. List one cause on each line Interval Between Immediate Cause (Final Physician/ PESPIRATOR FAILURE disease or condition } Medical resulting in death) Due to (or as a consequence of) Examiner PLEURAL EFFUSION Saguentially list conditions if any, leading to immediate cause. Enter Underlying COLORECTAL CANCER Exam The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🔲 Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date 27. Manner of Death of injury 28b. Time of 28c. Injury at (Month, Day, 5 Pending Natural work' Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animals. Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number M.D. 2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 4940 Eastern Avenue

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Greinus 12:05 1) N am 0 2011 23 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore F, more 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min Months 81 Yrs. Mary land 217-22-8599 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X☐ No Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16 Fusting Avenue United States 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Brinks Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William A. Greinus Caroline Wehrenberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1137 Mount Drive, Pasadena, MD 21122 Robert G. Sparrow, Jr. Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 2,2011 | Violetville, MD St. Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc 21 Signature of Funeral Service Licensee com allici.a 1328 Sulphur Spring Road Arbutus Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, En cephalopouthin Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4. Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 D (Vo 1 □ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

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Physician

/Medical

Director

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permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any injury or other traur

Baltimore, Maryland 21215-0036

shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate to the sequence of Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 1 Yes 2 → No this (Medical Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D47683 Transpord Miller M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltone mp 2835 Smith Avenue 21209 Kaymona Mither Surfe 31. Date-filed (Month, Day, Year)

JAN 31 2011 32. Registrar's Signatur State Registrar ORIGINAL

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Funeral Director		5. Social Security Number 6. Sec. 3 6.3 - 20 - 13.00 1 Usual Residence of Decedent	M 2 X F 7. Ag	e (In yrs. last 88	Yrs. Months		Hours Min		ate of Birth Jonth, Day, Y	ear)	9. Birth	place (State or Foreign
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nd 21215-0036 s filed within 72 hours after tal Hygiene. do other than "natural", o	Completed	15. Decedent's Er (Specify only highest gra Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5		life. DO NOT u	ork done	during most of wo	orking	1	6b. Kind of Bi		ndustry 1/7/
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Baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Men important: If item ZT is marke any injury or other traumatic once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. Placen	ce of Disposition (Nametery, crematory of	other place	ce) Z-	Date - / - 2	011 /	Oc. Location -	City or T	own, State MICHIGAN
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Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be all in by the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 2 should be all or the funeral director, page 3 should be all or the funeral directors.	omplete							-	24a. Was an autopsy perform	ed?	orior to co death?	opsy findings available ompletion of cause of
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To the Hospital or within 24 hours al To the Funeral D completed filled in	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examination only one) 3 Certifying Nurse	ner: On the basis of e	xamination a	and/or investigation, i	n my opini	on, death occurre	d at the tir	ne, date and	place, and du-	e to the ca	ause(s) and manner stated
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St. / Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatui	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Grauling, III 15:37 PM John January 27 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** altimore Agnes Mospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 1**X** M 2□ F 80 Director 10/30/1930 216-24-1571 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐Yes 2☐No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, BR533 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify: 3 Widowed 4 Divorced Korean White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Department of Defense 4 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Grauling, Jr. Mildred Warfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Mrs. Marion E. Grauling/ Wife 719 Maiden Choice Lane BR 533, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 02/01/2011 | Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licens Services PA; 1 2nd Ave SW; Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Acute Intarchan 6 YOUVS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Years Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ↑ Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P25498 January 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 900 NATH PANT CATON Balhmore Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 B. parker Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene CC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a Facility Name (if not institution, give street and numb Examiner City, Town, or Location of Death County of Death dica len DURALIE HILL 1ter MNE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) 02/06/192 1 X M 2 D F Months Hours Min. **Director** 361-03-3096 88 KY Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f shorex Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Anne Arundel Annapolis 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 Shipmaster Way 21401 Apt. 114 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: "natural", 3 Widowed 4 🔀 Divorced Specify Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence National Security Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert A. Goff Anna Aileen Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 9 permit. Fage 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Apt. 310 Lillian Malkus / friend 2900 Shipmaster Way Annapolis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington Nat. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. MO1357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ONEUMONIA Ph sician/ 50,2ATO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exa that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Month Pregnant at time of death Day Year Yes 2 No g Unknown g Unknown P.0. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has certificate 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 AVO ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospire. ...
within 24 hours after death.
To the Funeral Director: After thi
"----leted filled in by the funeral 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTER, GLON BURNIE ALDMOR MUDICAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01-23-2011 Elmer Leroy Gabel, Jr. 2017 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 😿 M 2 🗆 F Hours 05<u>~24</u>~1929 81 Yrs. 216-24-8749 MD Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No MD Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1329 Saratoga Drive 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ŏ 1 Never Married 2 Married Completed by 1 V Yes 2 □ No If Yes, Give 1 ☐ Yes 2 🔯 No Specify: Specify: White "natural", 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry iit. Page 1 and 2 should be filed within remaintent of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hardware Store 0wner Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer Leroy Gabel, Sr. Hattie Mae Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Irvin (Brother) 1329 Saratoga Drive Bel Air, MD 21014 anuanu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Bel Air Mem. Gardens 01-26-2011 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Preumococcal bacteremic Pheumonia disease or condition resulting in death) nknum Medical Due to (or as a consequence of): Examiner inknown 4 melanoma Sequentially list conditions Examine Due to (as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive Pulminan DISCRE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Ischemic Cardiomyopathy, Diobetes Melvin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 2 No Loutemie Lymphocytic Hospital or Attending Physician: The Chronic 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 XNo မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0065421 January, 23, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christa R. Fister, MO 500 upper chesapeake Drive, Bel Air, MO 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 31 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Cyril Gorham 6:45 P M 2011 anuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renassance Gardens Silver Spring Montgomery 8. Date of Birth (Month, Day, Year, Oct. 15, 1 Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Hours Min. California Director 571-54-0384 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland notified at Director Silver Spring 1 🗆 Yes 2 🔀 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 ral", or items 23a or Examiner must be Funeral #0G3104 20904 United States 3160 Gracefield Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. rmed Force Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1940-45 White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Investigator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gorham Hoch William Reagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Evelyn A. Gorham 3160 Gracefield Rd. #OG3104, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/25/2011 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Rapp funeral and Cremation Services Signature of Funeral Service Licensee Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician CAD (Coronary Artery Disease) disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed G.I. Hemmorrhage that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Radiation Colitis Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death signed by the a Linknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 TNO 1 Inpatient 2 ER/Outpatient 3 DOA မ 4X Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier death (Item 23a) (Type, Print) s of person who completed cause of 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 69 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth
(Month, Day, Year)
Nov. 17, Funerai Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours Min. New York Director 215-78-5804 50 Yrs 1960 Nov. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 2X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13708 Modrad Way #31 20904 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. 11 Administrative Assistant Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gillespie, Jr. Cerious Dolores Ann Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven M. Gillespie, JR. / Son 1401 Blair Mill Rd. #620, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/26/2011 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Rapp Funeral and Cremation Services MO0382 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Anema Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Ridney Vailore 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. this certificate has autopsy performed Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Grempler |< 4:11 Joan, 2011 anvary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death n/a Medical Center 345 St. Paul Place Baltimore 6. Sex Social Security Numb 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 □ F Hours April 4, 1947 Marv Tand 67 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at **Funeral Director** 28a-f MD Baltimore Phoenix 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13945 Blenheim Road 21131 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 K Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Melvin Charles Wheeler Volker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gustav Theobald-husband 13945 Blenheim Rd., Phoenix, MD item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₽ Page 1 1 KBurial 2 Cremation 3 Removal from State ± 5 Important: It any injury or once. Dulaney Vallev 4 Donation 5 Other (Specify) 2/3/11 Timonium, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service LicenseeWilliam G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Breast Cancer Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been si, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 X No 1 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred i or Attending F after death. (Month, Day, Year) **Natural** 5 Pending work after death. 2 🗌 No 1 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) M.P. P25683 January 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul Place Friedlander 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2011 park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 28,2011 7:20A. M J. Green Eleanor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Michigan 1 🗆 M 2 😾 F Months Hours Feb. 21, Year 935 370-32-4145 Director Usual Residence of Decedent octant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Harford Forest Hill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1621 Louanne Court 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married ☐ Yes 2 XNo 1 ☐ Yes X☐ No Specify: Specify: White If Yes, Give 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Stanley Oblak Mary Biawa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) %20 Park Manor Circle, Bel Air, Maryland21014 Caroline Layden permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Marys Cemetery 2-4-11 Williamstown, N.J. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland21214 Mense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracrania Physician/ disease or condition resulting in death) HOUR Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No reamon 24a. Was an After this certificate has autopsy perform 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 L No 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MELISSA GOMEZ JANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7066 McCLEAN BLVD PARKVILLE BALTIMORE Social Security Numbe 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Funeral Days Hours 768-22-0672 1 M 2 X F 28 Director 11-24-1982 TRINIDAD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD. BALTIMORE PARKVILLE 1X Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7066 McCLEAN BLVD. 21234 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Ex miner Armed Force Black, White, etc 1 Never Married 2 Married o. 1 Yes 2 No If Yes, Give Year or Dates. Completed by Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK "natural" 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NURSING ASSISTANT HEALTHCARE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PETER GOMEZ DIANNE PAUL other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is QUARRY SETTLEMENT ERIN RD. SIPARIA, TRINIDAD DIANNE PAUL (MOTHER) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 2 X Crem injury or Buria tion 3 Removal from State 4 Dor ation 5 Other (Specify) METRO CREMATORY 1-28-2011 BALTIMORE, MARYLAND oral Service Licensee JONATHAN . Signatur HIBNIR^{2.} Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immed te Cause (Final disease or condition Onset and Death 5 M60Th9 MEDULLOBLASTOMA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death Yes 2 No detached g X Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes Other: ျှ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

e Funeral Director: Affelted filled in by the fur Investigation 2 \(\subseteq \text{ Accident} \) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie R097025 mu crup 2011 30. Name and address o person who completed cause of death (Item 23a) (Type, Print) ORLEANS ST, DAVID KOCHBLOB, SUITEIM-16, BALTO, MD 21231 550 31. Date filed (Month, Day, Year 32. Registra s Signature State JAN31 Registrar

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Damon	s	Gilmore

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State of Maryland / Department of Health and Mental Hygiene	Vi	-	0	- Ener

		l-For State Registrar	Ce	rtificate of D	eath	Re	eg. No.	
Physiciai Nedical Examin	er	Decedent's Name (First, Middle,Last) Damer				2. Date of Deat Month January 24	Day Year 4, 2011	3. Time of Death 1559 hrs
		4a. Facility Name (if not institution, give s University Hospital	street and number)		City, Town, or Location of D Baltimore	eath	4c. County of Death	A
Funeral Director			7. Age (In yrs. I	· · · -	f Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birt Min. Aug. a	th(MM/DD/YYYY) 9. Bir Foreig Co	
Maryland 28a-f show aoy d at oocc.		Usual Residence of Decedent 10a. State 10b. County Mary Laud N 10e. Street and Number	10c. City	, Town or Location	Battimore		Da Citizan of Minat Cou	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho	<u>e</u>	515 S. Fultor	Ave.		Of. Zip Code		og. Citizen of What Cou	A
₩ 7.71	by Fune	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu No specify: Jsual Occupation (Give kind	ierto Rican, etc.)	White, etc.	ack
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ore, MD 2's land 2 should by Health and M If item 27 is miner traumatice		19a. Informant's Name/Relationship (Typ Andrew Tackson 20a. Method of Disposition	- cousin 20b.	Place of Disposition	Penrose Ave	or Rural Route Num Baltim Date	or City or Town, State Orc. Many 20c. Location - City or	dard
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Seprice License	M		e and Address of Ficility	1/31/11 after Full	Lardsdon reval Hom	ere Maryland
Physician	1	23a. Part I. Enter the disease, or complic failure. List only one cause on each		Do not enter the n	node of dying, such as cardi	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical			unshot wounds (2) of le to (or as a consequence of		orearm.			Death
	<u>je</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e to (or as a consequence o	of):				
cuted	티	(Disease or injury that initiated C	e to (or as a consequence o	of):				
exe and	Medical		AMENDED	_				
Box 68760, e death certificate be the attending physici ed for use as the buri	clan/	IF FEMALE: (3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth Pregnant at time of de 9 Unknown	2 Fetal o	leath 3 Ectopic pre	egnancy	23d. Date of delivery Month	y Day Year
P.O. E	2	Part II. Other significant conditions of	ontributing to death but not r	esulting in the unde	erlying cause given in Part I.		bacco use contribute to	
cords law requi	Completed					24a. Was a autops perform	sy prior to c m <u>ed</u> ? death?	topsy findings available completion of cause of
Vital Rec	ן מ	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 Inpatient 2 ✔	ER/Outpatient 3	26.Place of Death (Che	eck only one) ursing Home 5 7	Residence 6 Other	
Division of Nal or Attending Ph. Ital or Attending Ph. Ital or Attending Ph. Ital Director: After tilled in by the funeral	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month Day Year) Jan 24, 2011	28b. Time of Injur 1524 hrs	1 Yes 2 ✔ No	Subject shot		
Divis		3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, fa	actory, office building, etc.	or Town, St	treet and Number or Ruitate) Cole Street, Baltimore	
Divis To the Hospital or A within 24 hours after To the Fuoeral Dire completely filled in b	edical	one) 2 Medical Examiner: 0	: To the best of my knowled in the basis of examination a nd manner stated.					
	≥ 2	29b. Signature and title of certifier	V		29c. License number O.C.M.E.		29d. Date signed (Mor January 25, 2011	
			dical Examiner 900	W. Baltimore S	Street, Baltimore, MD	21223		
Sta Registr	~~	31. Date filed (Month, Day, Year) JAN 3 1 2011	39. Registrar's Signatu	ire				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per DVR G912 2/02/2011 JH. State of Maryland / Department of Health and Mental Hygique 1 - For State Registrar b Certificate of Death Reg. No. 2. Date of Death 2011 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hans 6:30 AM avice Jan. 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N S Tauli CIMO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/16/28 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2 F 82 Yrs NC Director 216-58-4188 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD N/A Baltimore 1⊠Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2325 Hollins St. 21223 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mudical Experiment once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 🌋 No Specify: 2 3 Widowed 4 □ Divorced Amer. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self Elementary/Secondary (0-12) College (1-4or 5+) House Keeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Newkirk Oscar Newkirk 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Hans/Son 1934 E. 31st St.,(apt.1F),Balt.,MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 1/31/11 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage -ng **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 XNo Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 Yes 21 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Noterifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of ced ier 29c. License number 29d. Date signed (Month, Day, Year) January 25, 2011 m 23a) (Type, Print) Jone Floor Month, Day, Year JAN 31 2011 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 954 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IKINS 517 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Balto Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Min (Month, Day, Director 213-32-7348 72 2-2-1938 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Balto Randallstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8619 Lucerne Road 21133 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Various Employers Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Oscar Hawkins Jessie Blue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd Hawkins, Jr-Son 8619 Lucerne Road Randallstown, MD21133 20a. Method of Disposition

X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 Donation 5 Other (Specify) Mt Carmel 1-21-2011 Balto, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or linjury that initiated page 1979). Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown Day Year the. g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No 1 🗆 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Sesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the bast of my knowledge should be caused at the time, date and place, and due to the cause(s) and manner at stated. (Check 29c. License number 20) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 e filed (Month, Day, Yea 32. Registr State 2011 Registrar

11-0058	1	
Jerrious	D.	Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

errious D. Hill	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death	01955
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	3. Time of Death
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	1400 1110
Funeral	Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	
Director	213-62-5154 1 Mm 2 F 54 Yrs. Months Days Hours Min. 2-8-1956 Foreign	
v any		10d. Inside City Limits
saryland Sa-f show at once.	MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count	1 Yes 2 No
the Maryland as or 28a-f sh etified at one	1022 Kevin Road 21229 USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-falumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1	an Indian, Black,
s after d	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify:	
215-0036 be filed within 72 hours after half Hygiene. rked other than "natural", ent, the Medical Examine Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	dustry
5-0036 Jed within 7 Hygiene. other than the Medica	12th grade 2½ years Self Employed Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	Shop
21215 21215 wald be file Mental H. marked of cevent, the	William Robert Hill Shirley C. Coleman	7. 0.10
e, MD 2121 I and 2 should be fil Health and Mental I Tiem 27 is marked Traumatic event,	William Hill-Brother 2539 Aisquith Street Balto, MD 23	,
늘 중성불의	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T	own, State
Baltimore, permit. Pages la permit. Pages la Department of Hei Important: Wite injury or other tr	4 Donation 5 Other Specify: Oaklawn Cemetery 1-29-2011 Baltimore 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility March East F/H	e, MD
on ឱ្យអ៊ីទ Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	21202 Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of Methadone Intoxication	Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
ted Insit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C.	
uted id ansit	events resulting in death) Last Due to (or as a consequence of):	
0, : be executed sician and outrial - transi		= - 1
Ox 6876C eath certificate attending phys for use as the b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da	ay Year
). Box 6876 the death certificate by the attending phy ched for use as the Physician/M	4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.C.	1 Yes 2 No 3 Proba	ne cause of death?
Records, The law require ficate has been sig, page 2 should bb	24a. Was an 24b. Were auto autopsy prior to co	ppsy findings available mpletion of cause of
tal Recordant The la certificate has setor, page 2	performed? death? 1	2 No
of Vital ng Physician: After this certi nneral director n: To Be	examiner?	-
nding P. th. r: After te funera	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 28b. Time of Injury 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred	- 4 1 - 1
Division of spiral or Attending hours after death. neral Director: After filled in by the function of the fun	2 X Accident 3 Suicide 6 Could not be determined 1-19-11 2230 hrs 1-18-2 X No Subject ingested means 286. Decation (Street and Number or Rura or Town, State) 2510 Garr	Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedical Certific	4 Homicide determined (Specify) residence Baltimore, Md. 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Howithin 24 h To the Fun Completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Monte	
	O.C.M.E. January 22, 2011	n, Day, rear)
	30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	31. Date filed (Month, Day, Year) 22, Registrar's Signature	
Registrar	JAN 3 1 2011 A DELLA DEL	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :15 AM tan Medical lanuar 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death amari altimore NIA 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Day Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 213-98-862 1 M 2 □ F Country) **Director** Yrs MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Nes 2 No Honore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 If Yes, Give Year or Dates. 2 3 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nn any injury or other traumatic." (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother Katto IQ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location, - City or Town, State Date 1 Burial 2 Termation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Si tur of Funeral Service uneral 22. Name and Address of Facility HOWELL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Respirator disease or condition resulting in death) Medical Due to (or as a consequence of): *Examiner Respirato S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit erebrai resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seizure disorder 2 100 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performe ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation within 24 hours after death To the Funeral Director: / completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0062735 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 5601 Loch Raven Blvd, Baltimore, Mary land 21239 Johnas parno MD filed (Month, Day, Year) 32. Registrar's Signature State JAN31 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a b per fh g913 3-15-11 yt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Anthony
4a. Facility Name (If hot institution, give street and number) 19 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb 23 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex '. Age (In yrs. last birthday) **Funeral** 218-60-602 MI Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at 1 Dres 2 □ No Director MD 1+1 more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 2120 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4 or 5+) Irans 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harcum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3818 JING roda 1+0 tarcum 20b. Place of Disposition (Name of cemetry, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important; If ite any Injury or ot 1 Surial 2 Cremation 3 ☐ Removal from State 5 Other (Specify) Himoro 3-14-11 4 Donation 22. Name and Address of Facility 21. Signature of Euneral Service Lice toweld 4600 hiberty Balto. MD 2128 Haghts Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a chardiac or restrictions are story arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** hemorrhag Intracerebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in tigled as expenses or injury that in the cause (Disease or injury that in the ca Examine Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, director, page 2 should be 1 Yes 2 No 3 Probably 4
☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗌 No 2/ or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 🗌 Yes 2 No 2 ☐ Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 January 19 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ducku 600 North Wolfe St, Baltimore, MD, 21287 JOSh jorth 31. Date filed (Month, Day, Year) 32. Regist State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jamuary 2011 Year Physician/ Henry Hepner 10:05pm_M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore County Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🖵 M 2 🗆 F 218 07 9161 92 Yrs Director 1918 ebruary 18 | Baltimore Maryland Usual Residence of Decedent 28a-f shov 10b. County death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Baltimore Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road Apt. F 104 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc ö Completed by 1 Never Married 2 Married 1XX Yes 2 ☐ No If Yes, Give Year or Dates. W hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 ☐ Divorced "natural" Specify: White W II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Welder N/A Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Hepner Stella Wieloch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANUARY Christine Hepner 218 W Timonium Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Gardens of Faith Cem. January 31 2011 4 Donation 5 Other (Specify) Baltimore, Maryland permit. Signature of Funeral Service Licensee 2. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Boad Baltimore Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a con a quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for t in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No **YENRY** Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e cause(s) anu ma.... 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Ernestine Wright, 2300 DULANEY VALLEY ROAD MD 21093 M.D.TIMONIUM Day, Year) 1 2011 (Month, 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #788 Per FH G913 3/09/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 27, 2011 5:30 p M Hadlev Nancy Kav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 500 Virginia Avenue, #408 Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 7. And I'm yrs. last birthday) Septh, 29 9. Birthplace (State or Foreign Funeral Min. Hours 1 M 2 Q Marviand Director 218-42-3119 64 63 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 500 Virginia Avenue, # 408 01/27/2011 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vancy Hadley ည Shroen Katherine Listman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Freeburger Oddo-cousin 2150 SW 10th Ct., #316, Delray Beach, FL 33445 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv Corp 1/31/11 Towson, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) complication Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause (Disease or linjury Due to force a considerate of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28a. Date ... (Month, Day, Year, (Month, Day, Year, Year)

28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. (Specify)

4 death occurred at the time, date and in my opinion, death of the course of 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, CT? City or Town, State) 501 Y = 11.11 She pan CT? Park VILLE Mayland 2123 determined Shopping Center in Store Park VILLE Maylong
Certifying Physician: To the best of my knulledge, death occurred at the time, date and place, and due to the cause(s) and manner an stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 28,201 who completed cause of death (Item 23a) (Type, Print) utherville, Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 31 Registrar

DHMH 17 Rev 7/2009

11-00769 David M. Herbi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vid M. Herbig	1.	St - For State	ate of Maryla	and / Depai <i>Cert</i>	rtment of	Healtr Death	n and	Menta	Hygierie	Reg. No.		9/0
Dhyaiaia		egistrar I. Decedent's Name (First, Middl	e,Last)	-					2. Date of D	eath	3. Time of	Death
Physicia edical Examin		David M.	Herbig						January	27, 2011 Year	1634	hrs
		ta. Facility Name (if not institution	n, give street and n	umber)	4	•		ocation of D	eath	4c. County of		
		Baltimore Washingtor	Medical Cente	er		Glen B	Burnie			Anne Aru		
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Director		212 20 4400	1 M 2 F		77 Yrs.	Months	Days	Hours		5, 1933	Country) Maryland	i E
	-	212-30-4409 Usual Residence of Decedent		L								
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ath w		1 Never Married 2 X M	arried Armed F	orces?	If Ye	es, specify	Cuban,	Mexican, Pu	uerto Rican, etc.)	VVIIILE	, 810.	
ier de		3 Widowed 4 Div	vorced If Yes, Give Ye		1	Yes 2	X No	specify:		Specify:	White	
irs af	틧	15. Decedent's Education (Spe	cify only highest gra	ade completed)	16a. Decedent	's Usual C	occupation	on (Give kind OO NOT use	d of work done	16b, Kind of Bus	siness/Industry	
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21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any c event, the Medical Examiner must be notified at once.	Be	Robert L.		ſ						argent	2: 0:4	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a. Informant's Name/Relation	ship (Type, Print)							Number, City or Towr		")
MD 12 sh th and 127 is		Gail Herbig -	wife	1.00					Dr., Pas	adena, MD	City or Town, Sta	ite
Titer Tra		20a. Method of Disposition 1 X Burial 2 Crematic	n 3 Removal		Place of Dispos crematory or oth		e or cem	etery,	Date			
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Baltimore, permit. Pages 1 an Department of Hea Important: If itel injury or other tr	1	21. Signature of Funeral Service	Ligensee	M	22. N	lame and	Address	of Facility	Stallin	gs Funera	1 Home,	PA
E F P E	- 4	Much	1 /tax	Ilino	/// 3:	111 M	lou <u>nt</u>	ain R	d., Pasa	dena, MD	21122	imate Interval
Physician		23a. Part I. Enter the diseas in of silure. List only one cause	r completions that	caused the death	To not enter the	he mode o	f dying, s	such as card	diac or respiratory	arrest, shock, or nea	Between	en Onset and
/Medical		Immediate Cause (Final diseas	Carbon M	onoxide Intox	ication							Death
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Physic r this al dir	ပို	1 Yes 2 No 27. Manner of Death		te of Injury	28b. Time of			y at Work?	28d Desc	ribe how injury occur	red	
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apita hours neral	👨	4 Homicide	(-,	fy) Garage	dae death see	erod at the	e time d	ate and plac		cause(s) and manne		
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	<u>8</u>	(Check only one) 2 Medical E	kaminer: On the bas	is of examination	and/or investiga	ation, in m	y opinion	, death occ	urred at the time,	date and place, and	due to the cause(s)
To tl To tl	Medical	29b. Signature and title of cert	and manne	er stated.				e number			ned (Month, Day,	
	-	1 1 2 1	11 . 1)			O.C.	M.E.		January 2	8, 2011	
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+1		30. Name and address of pers Pamela E. Southall,	on who completed o	ause of death (Itel nt Medical Ex	m∠3a) aminer 90	0 W. B	altimor	e Street.	Baltimore, M	D 21223		
1				Registrar's Signa	2							
	tate	31. Date filed (Worlth, 1984;1/4)	11) [1/2 222 32	realisman a city	acres							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hopkins 28, Lorene 11:40 a M January 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ivy Hall Nursing Center Middle River Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Mir 236-20-7149 November 27, 1922 Wast Virginia Director 88 Yrs. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c, City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director Baltimore 1 Yes 2 No Maryland Dundalk 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7428 Holabird Avenue 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Office Clerk Banking Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Mollohan Prudy Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Hopkins Daughter 9125 Garland Avenue, Surfside, Florida 33154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 Burial 2 XCremation 3 Removal from State Bayview Crematory Baltimore, Maryland 29, 2011 4 Donation 5 Other (Specify) Sign ure of Furferal Service Licen ee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. M 23a. Part 1. Enter the diseas or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final e Mentia heimers Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 N 1 🔲 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After (Month, Day, Year) 1 Natural 2 Acciden 3 Suicide 5 Pending 2 🔲 No M 1 Tes Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifie 61907 SON Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKWUM a Ebo, 1124 Mace Avenue, Bultimore 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3) 3011 1:2)A-M ames hnuary /Medical c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hospital Baltimore agnes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 Dave | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F 241-46-0599 Vrs 20 1935 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Jown or Location show event, the Medical Evaning must be notified at 1XYes 2 □ No Director HIMOre 28a-f 10g, Citizen of What Country 10e Street and Number 10f. Zip Code ò 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 h and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 101 18. Mother's Name (First, Middle, Maiden Sur 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trac Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20a. Method of Disposition 20b. 1 ■ Burial 2 Cremation 3 Removal from State butus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn Greene Service 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espiratoru **Physician** tallive /Medical Due to (or as a consequence of): Pulmonary Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Hobe Stosi and -tran Due to (or as a consequence of): physician a s the burial-Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for □Yes 2□No o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Onknown 2 🔲 No 3 Probably 1 Tyes plnous Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 No 1 ☐ Yes Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 🔲 Inpatient 2 TR/Outpatient 3 DOA ပို ð this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the P 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 056418 272011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Caton Ave, Baltimore Mason 900 Tonya 32. Registrar's Si 31. Date filed (Mg State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 Gladys 2011 Μ. Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Himore laryland Genera If Under 1 Year If Under 24 Hrs. Ade (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) Funeral Months Days 1 🗆 M 2🗶 F Min. Month, Day, Year 38 Hours 72 GA Director 267-52-2390 Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore na 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a with 331 Allendale Street 21229 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... _... Armed Forces? 1 ☐ Yes 2 💢 No 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alzona Fields Enoch William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Angelique L. Johnson 331 Allendale Street Balto,MD 21229 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Μt Carmel Cem 1-29-2011 Balto, MD March East F/H Signature of Funeral & rvice Licenses any in 22. Name and Address of Facility Brank Me Ren 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Éxaminer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transi and that initiated events resulting in death) Last Due to (or as a physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a q Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo 24a, Was an has autopsy certificate l Yes 2 D director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DCA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature apol title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print houg 32. Registrar's Signature 31. Date filed (Month, Day, Year State **JAN 31** 2011 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 01 Pear1 D. Johnson 01 2011 2:13 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Forestville Nursing Forestvill*e* 8. Date of Birth (Month, Day, Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Hours Min Director Clinton. 244-34-8100 04-03-1926 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City Town or Location 10d. Inside City Limits Director 1 🔲 Yes 2 🗌 No Md Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7420 Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black White etc. þ 1 Never Married 2 Married ☐ Yes 2XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 lh and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Upper Marlboro 7th Deputy Sheriff Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Johnson Laura Booker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette D. Inge (daughter) 8990 Woodyard Road, Clinton, Md 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Chesapeake Crematory 01-15-2011 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 20019 Dunn & Son Funeral Home 5635 Eads St. Wash D NE23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a co Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ A 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? ✔ Natural iniury 5 Pending Accident 1 Tes 2 🗆 No within 24 hours after death

To the Funeral Director; / Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year) , 2011 mo

State Registrar . Date filed (Month, Day,

JAN 3 1 2011

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 26° 2011 4:45 D. Johnson Ам Anne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Towson Towson Baltimore 8. Date of Birth
(Month, Day Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1 - M 2 X F Mary Land Director 216-20-4655 85 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 21286 1646 Mussula Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Bosse Pfeil August 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Barbara A. Johnson/ Daughter 1646 Mussula Rd. Towson, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-28-11 Woodlawn, MD. orraine Park Cem. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or resulting in death) Last taxia Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 month Pregnant at time of death 1 Yes 2 Dunknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 2 1 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Director: / 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Equipment: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Charging Nurse Plactioner: To the best of my knowled as death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific OSLEY Drive Touson, MO 21204 dress of person who completed cause of death (Item 23a) (Type, Print) J. HIRPARA 7505 M

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 1 2011

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) January Day 27, 2011 Physician/ Jankowiak Conrad Joseph Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Care Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M 2 F Funeral Hours Months Ju^M°♥′2^{Day}1^Y9′53 214-58-7659 57 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a State Director Md. Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 U.S.A. 23 Charlene Lane should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural". or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ 1 Yes 2 No Specify. Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Longshoreman Union Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Paul Jankowiak Mary Rang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 slument of Health a tant: If item 27 i Charlene Lane Essex, Maryland Linda Becker / Sister other Baltimore. 20b. Place of Disposition (Name of Januæry 20c. Location - City or Town, State 20a, Method of Disposition Bayview Crematory 29, 2011 Baltimore, Maryland Department of Important: If it any injury or o ō <u>+</u> 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service License 22. Name and Address of Fackbaczorowski Funeral Home, P.A. <u>Dundalk Avenue Baltimore Md.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Immediate Cause (Final UNG ancer Physician/ disease or condition resulting in death) Medical Due to (or as a con quence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or iinium that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Santa in the past 12 months? Yes 2 ☐ No signed by the at d be detached for 1 Yes 2 L g Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Records, Be Completed should 24a. Was an s certificate has the director, page 2 s performe Yes 2 XN 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical examiner? Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) WOSPICE Other: 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Natural 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred nours after death.

neral Director: After the filled in by the funeral Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 6701 N. Charly ST rowson MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI CHANCES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

months

1 Yes 2 X No

Macryland

14. Race - American Indian,

Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

5:45 PM

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

JAN 3 1 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decede ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0623A M ANWARY Medical Facility Name (if not institution, give Town, or Location of Death County of Death Examiner 4IN9tOR BURNIE Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Davs Hours Min. 02/23/23Country) Maryland Director 79 Yrs 217-26-8315 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No MD Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral with 1 7883 Crilley Road Apt. 469 21060 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home 6 vrs. permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Elizabeth Hatter Bernard Linton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Osprey Circle St. Marys, GA Mr. Barry L. Kouns / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 02/02/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, MD Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation MO1121 ' Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Septic disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Disease schemica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Fibri lliation Atrial To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day the detached 1 ☐ Yes 2 L 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease DYUNG 1 Yes 2 No 3 Probably 4 Unknown , page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? Disease 24a. Was an hours has autopsy perform certificate 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 X Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Deat 28b. Time of Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director; 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1/ 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) te zhang M.D. D0069274 JANUART 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HE ZHAWG, 301 HOPITHL DRZVE, GLENBURNIE, MD. 2016 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Kraig	David	Krixer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1					
State of N	Maryland /	Department	of Health	and Mer	ntal Hygiene

aig David Krix	er	State of Maryland / Departme 1- For State Certifica	nt of Health and Mental te of Death		n No	
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Deat		3. Time of Death
ledical Exami	ner	Klaig David Klikel		Month January 20	Day Year D, 2011	1113 hrs
		Facility Name (if not institution, give street and number) Jumpers Circle	4b. City, Town, or Location of De Nottingham	eath	4c. County of Death	
Funcial		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		Ure 8 Date of Birt	Baltimore Cou	•
Funeral Director		217-60-2709 ₁ K _{M 2} F 59			Foreig	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	<u></u>		10d. Inside City Limits
*	L	Md. Balto.	Nottingham			1 Yes 2 No
Maryland 28a-f show 1 at once,	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		70 Jumpers Circle	21236		USA	
death with	Completed by Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		14. Race - Ameri White, etc.	can Indian, Black,
er deat	Fur	3 Widowed 4 Divorced If Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,		
urs aft	b	15. Decedent's Education (Specify only highest grade completed) 16a De	1 Yes 2 No specify:	of work done	Specify: Whit	
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use	retired)	Social Secu	rity
vithin ene.	ם	12th S	upervisor		Administrat	ion
1215-0036 Id be filed within 72 hours after fental Hygiene. aarked other than "natural", event; the Medical Examiner		17. Father's Name (First, Middle, Last) Clarence Krixer		me (First, Middle, M		
212 ald be Menta marke	o Be		Mailing Address (Street and Number	Dorothy Page Number 1		Zin Code)
AD 2 show h and 27 is					, Md,. 2123	
Te, I I and Healt Fitem		20a. Method of Disposition 20b. Place of I	Disposition (Name of cemetery, or other place)	Date	20c. Location - City or	Town, State
Pages nent of n oth	П	Telloval follower		-24-2011	Balto. Md.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Schimunek	FuneralHom	e
		23a. Part I. Enter the disease, or complications that caused the death. Do not of	9705 Belair Road	d Notting	gham, Md. 2	
Physician /Medical		failure. List only one cause on each line.				Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Chronic alcoholism Due to (or as a consequence of):	complicated by n	ypotnermi	a	Deau
		Sequentially list conditions, b			U	
	Examiner	if any, leading to immediate Due to (or as a consequence of):				
sit sd	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				3
50, te be executed nysician and s burial - transit	ledical	d. X UNPENDED AMENDED				
60, tte be e hysicia		AMENDED 23a, 27, 28a-f, per IF FEMALE: 23c. If yes, outcome of pregnancy	ME g913/ 3/3/11	TT	23d. Date of delivery	
Box 68760, can be death certificate be the attending physic ad for use as the burned for		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pre	gnancy	_	ау Үеаг
OX (eath ce attender use	sici	4 Pregnant at time of death 5 Yes 2 No 9 Unknown	Other (Specify)		1	
T the de by the ached f		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ires that the signed by	å P			1 Yes	2 No 3 Proba	ably 4 🗹 Unknown
of Vital Records, is Physician: The law require the secrificate has been sineral director, page 2 should be	Completed	0		24a. Was ar		opsy findings available ompletion of cause of
ecc he lav	E			perform	ned? death?	
Vital Reco bysician: The law this certificate has I director, page 2 s	BeC	25. Was case referred to medical	26.Place of Death (Che			
Vit	릵	1 V 165 2 140		sing Home 5 R	esidence 6 🗸 Other:	Scene
ding Ph		1 Natural 5 Day, Year)	e of Injury 28c. Injury at Work?	²⁸ d Byeck	wingested a	lcohol and
Division tal or Attendin rs after death. al Director: A led in by the fu	gti	2 Accident Investigation Id 1/20/11 Id 1	1:10 am		sed to cold	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Certification:	3 Suicide 6 Could not be determined (Specify) fd residen		or Town, Sta	reet and Number or Rur ite) 70 Jumper am, MD	's Circle
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a			
To the within To the Comple	Medical	one) Medical Examiner: On the basis of examination and/or inversarial manner stated.	stigation, in my opinion, death occurre	d at the time, date a	nd place, and due to the	cause(s)
	Σ	29b. Signarture and title of certifier	29c. License number		29d. Date signed (Moni	th, Day, Year)
		(a lukeul)	O.C.M.E.		January 21, 2011 	
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W	/ Baltimore Street Baltimore	. MD 21223		
Sta	ite		The state of the s	, = 1=20		
Regist	_	JAN 3 1 2011 Brown A.	del			
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68760 Box (P.O. Division of Vital Records,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 26. 2011 JOSEPH. **JACOB** KAT7 11:15P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 7928 Stevenson Road Pikesville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 17, 1927 **Funeral** 9. Birthplace (State or Foreign 1**X**M 2 □ F 214-24-6202 Days Hours Months Director 73 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore Baltimore 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7928 Stevenson Rd. 21208 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates. 1944-45 "natural" 3 🗆 Widowed 4 🗆 Divorced Completed Specify. white other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) self-employed 5+ manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Katz Irene Zamoiski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Barbara Katz/wife 7928 Stevenson Rd. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Green Mount Crematory | Jan. 28,2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 2 John b. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Palt UMI DIG OSCIAATIO2 Medical Due to (or as a consequence of): Examiner FROMPAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year per 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis or examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the I** only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIASSEN 2700 17601th OSARRY CAKE 31. Date filed (Month, Day, 32. Registrar's Signature State

✓ DHMH 17 Rev 7/2009

Registrar

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 p_M Katherine Adelle Lee 18 Medical 6:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dulaney Manor Care Balto Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You 1-27-**Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours Min Country) **Director** 157-18-2288 83 Yrs. Ĩ927 Usual Residence of Decedent show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Md Balto Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6644 Glen Barr Ct Apt B 21234 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Cols 12th grade Bus Aide Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any oriant or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Otha Dabney Maude Dabney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Lee, Sr-Son 6644 Glen Barr Ct Apt B Towson, Md 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green MtZion 1-25-11 Phoenix, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Dementia Onset and Death Enysician/ End disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, has been sign e 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performe Yes 2 No 1 Yes Be 25. Was case referred to nedical examiner? 26. Place of Death Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 \square No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Registrar

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30. Name and didress of person who completed cause of death (Item 23a) (Type, Print)

7505

32. Registrar's Signature

HIRPARA MO

31. Date filed (Month, Day, Year)

JAN 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time.of Death Physician/ January January 4'00A M OK Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death Examiner KING War DNIGO James roithersb 8. Date of Birth Social Security Number last birthday **Funeral** Min. -84 Months Hours (Month Pay, Year) 2 The Ca Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🛛 No MONTGOMER thursbur 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a Funeral "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?/
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black. White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. ASIAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary S anday (0-12) College (1-4 or 5+) DOMESTIC touse Be permit. Page 1 and 2 should be filed Department of Health and Mental Hys Important: If item 27 is marked oth any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) HONG-WOO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) nTer doug 20b. Place of Disposition (Name of celmetery, crematory or other) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ture of Funeral Service Deensee 10794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final disease or condition Ischemic cardiomy Ph_sician/ Opal Medical resulting in death) **Examiner** Sequentially list conditions, if any localing to interest cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident within 24 hours after death To the Funeral Director, 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) January 25. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C SWG W. Lee P.O., BOX 16578 M.C BOX 2 an W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 Registrar

M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eWIS Month 2:300 M Medical Mualy 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death id tark If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, **Funeral** 7. Age (In yrs. last birthday, 1 M 2 - F 9. Birthplace (State or Foreign Director Country) Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examine. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits more 1 Yes 2 No 10e. Street and Number 10f. Zip Code be 10g. Citizen of What Country? Funeral 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Ferces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. 1 Nes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 No 1 Yes 2 No Specify. 3 Widowed 4 Vivorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/S conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 tenhwu timore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Funeral Service 21. Signature 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, acute myocardial Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): ^{*}Examiner mellitus diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events hyperlipidemia resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ▼ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 🗌 No Yes 2 1 Tes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X/No 1 🗌 Yes ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury ☐ Accident Director: Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital of within 24 hours a To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Balanton D0055157 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3HARON BALANSON 9600 Rel Howard MD 21052 North Point 31. Date filed (Month, Day, Year) State 32. Registrar's Signature JAN 3 1 2011 Registrar

11-00652 William Lowry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ertificate o	f Death		, 9	Reg. No.	
Physic Medical Exan			ast) Lee Lowry Jr				2. Date of De		3. Time of Death
		4a. Facility Name (if not institution, St. Agnes Hospital		<u> </u>	4b. City, Town,	or Location of D		4c. County of	of Death
Funera			Sex 7. Age (In yrs.	last birthday)	Baltimore	ear If Under 24	Hrs. 8. Date of B	Birth (MM/DD/YYYY	9. Birthplace (State or
Directo		215-74-6822	X M 2 F 45	Yrs	Months Da		Min. June	28 1965	Foreign Country Maryland
any		Usual Residence of Decedent 10a. State 10b. County		. Town on Land			Journe		
* .	l.			y, Town or Local					10d. Inside City Limits 1 Yes 2 X No
farylan 28a-f si	Director	10e. Street and Number	more Ha	Lethorpe	10f. Zip Code			10g. Citizen of Wh	
th the Maryland 23a or 28a-f sho	ļ	444 Caledonia A	venue		21227			USA	
5-0036 ed within 72 hours after death with the Maryland tygiene, other than "natural", or items 23a or 28a-f she Me Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent Ever in ted Armed Forces?		is Decedent of H es, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 14. Race White	- American Indian, Black, , etc.
after de		3 Widowed 4 Divorc	1 Yes 2 X No	1	Yes 2 X N	o specify:		Specify:	White
hours a natura Exami	ed by	15. Decedent's Education (Specify			t's Usual Occupa			16b. Kind of Bus	siness/Industry
136 thin 72 hours it. te. than "naturi	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	disab1	_		, ,	disab	lod
		17. Father's Name (First, Middle, La	•			18.Mother's Na	ame (First, Middle	Maiden Surname)	
2121 uld be fi Mental I marked	o Be	William Joseph 19a. Informant's Name/Relationship					y Ann Gil		
MD 2 d 2 shoul lth and M n 27 is m	Ĕ	Cheryle Grow-Si						mber, City or Town	n, State, Zip Code) Land 21227
		20a. Method of Disposition			ition (Name of ce		Date		City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation 3		lantic	Cremato		an.28,20	l Glen B	urnie MD
Baltimo permit. Page Department o Importaot: injury or oth		21. Sign ture of new Service big				s of Facility A	norose Fu	neral Ho	me of Lansdown
Physician		23a. Part I. Enter the disease, or cor	nplications that caused the death	n. Do not enter th	19 Hammo	onds Fer	cry Road	Lansdown rest, shock, or hea	e MD 21227
/Medical		failure. List only one cause on	each line. a. Hypertensive A						Between Onset and Death
zxammer		or condition resulting in death)	Due to (or as a consequence of						
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):					
1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
and and transit			d						
Box 68760, death certificate be executed the attending physician and of for use as the burial - transi	edical	X UNPENDED			per me	g913 3-	7-11 vt	l as note	ed .
3876 rtificat ling phy as the	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg		al death 3	Ectopic preg	gnancy	23d. Date of d Month	lelivery Day Year
OX 68 eath certif	Physician	1 Yes 2 No 9 Unknow	4 Pregnant at time of de	anth =	er (Specify)				
. 4 . 4		Part II. Other significant conditions	1	esulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
of Vital Records, P.O og Prysiciao: The law requires that t ther this certificate has been signed by neral director, page 2 should be detac	d by	Chronic Rena	l Failure, Morl	oid Obes	ity		1 Ye	s 2 🗹 No 3	Probably 4 Unknown
ords Iw requas been	Completed						24a. Was auto		ere autopsy findings available or to completion of cause of
tal Rec	8						perfo 1 ✓ Yes		ath? ✓ Yes 2 No
ital sictao: s certif irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Innationt 2	FB/0-4-4-1		of Death (Chec			
of V ig Phys fter thi neral d	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of In		ry at Work?		Residence 6 how injury occurred	Other:
ion tteodin teath. tor: A	ation	1 Natural 5 Pending 2 Accident Investiga	(Month, Day,Year)		1,	Yes 2 No			
Division tal or Atteodi rs after death.	Certification:	3 Suicide 6 Could no determine	t be 28e. Place of Injury - At he	ome, farm, stree	, factory, office b	uilding, etc.	28f. Location (or Town, 5		or Rural Route Number, City
Hospital 24 hours Fuocral tely filled		4 Homicide	(Ороспу)	an dooth one we			1		
To the Ho within 24 P To the Fu completely	edical	(Check only one) 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination as and manner stated.	ge, ueam occurr nd/or investigation	on, in my opinion	, death occurred	d at the time, date	se(s) and manner a and place, and due	s stated e to the cause(s)
F×FS	ž	29b. Signature and title of certifier	-67/1/mg	30	29c. Licens				(Month, Day, Year)
		celo falle	Neel	<u> </u>	O.C.I	М.Е. 		January 25,	2011
\emptyset		 Name and address of person who Victor Weedn MD JD 	completed cause of death (Item assistant Medical Examir	,	Baltimore S	treet, Baltim	ore, MD 2122	23	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire					
Regist	rar		explicate for sufficient	Mal					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G911, 1/31/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2ŎĨ1 4:05 A M John Leiman Charles January 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Towson Edenwald 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 - F Months Days Hours Min Mary Land Yrs 917 219-01-0321 Usual Residence of Decedent 10h County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 K No Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? **USA** 21286 800 Southerly Rd. #414 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1X Yes 2 ☐ No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Psychology School Psychologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marie Jacob Charles Leiman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Southerly Rd. #414 Towson, MD. 21204 Jane I. <u>Leiman/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 5 2 Other (Specify) 1-28-11 Towson, MD. 4 Donation Hilltop Service Co. 22. Name and Address of Facility son Funeral Home, Inc. Signature of Jure York Rd. Towson, MD. 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death
ZO CARS Immediate Cause (Final disease or condition resulting in death) ARTERY SHUOSE DISEASE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician Division of Vital Records, P.O. Box 68760 nse

for

Physician/

Medical

10a, State

MD.

Examiner

Funeral

Director

or 28a-f show notified at

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ural", or items 2 Examiner mus

"natural",

th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I

permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event,

Director

Funeral

Completed by

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. Completed by Be 은 Certificate: Medical

IF

31. Date filed (Month, Day, Year)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ppic pregnancy er (spec <i>ify)</i>		23d. Date of delivery Month Day Year			
Part II. Other significant conditions co	ontributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
CHRONIC K	DNLY DISEASE, S	THUE 4	1 Xves	2 No 3 Probably 4 Unknown			
ATRIM FI	BRILLATION		24a. Was an autopsy performed?				
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner? 1 🗌 Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	6 ☐ Other (Specify)					
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		work?	ury occurred				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Exami	sician: To the best of my knowledge, death occure iner: On the basis of examination and/or investigation se Practioner: To the best of my knowledge, death of	n, in my opinion, death occurred at the	ne time, date and place	ce, and due to the cause(s) and manner stated.			
20h Signature and title of cortifier		20a Licanca number	204 5	Pata signed (Month Day Your)			

D0020795

Towson, MD 21204

28

2011

✓ DHMH 17 Rev 7/2009

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

John G. Lavin 7600 Osler Dr. Ste. 113

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Honaid Moye 4: 45 AM Jan 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Umiversity of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 041-60-5960 7. Age (In yrs. last birthday) 50 Yrs. 8. Date of Birth (Month, Day, Year) 4-27-1960 6. Sex. 1 X M 2 □ F 9. Birthplace (State or Foreign **Funeral** Director Ct Usual Residence of Decedent 28a-f show I Hygiene. I other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Balto Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21239 1220 Winston Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Flight Attendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Henry Williams Christine Moye 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Mix Avenue Apt 3 M Hamden, Ct Christine Covington-20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Greenmount injury or 1-27-2011 Balto, 4 ☐ Donation 5 ☐ Other (Specify) March East F/H Signature Fun ral Service Licenses 22. Name and Address of Facility Mulia 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown s been signed b Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 death?
1 Yes 2 No certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral D Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Dacchus, 1336374321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bacc 22 South street Baltimore 31. Date filed (Month, Day, Year)

JAN 3 1 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond Charles Machlinski, Sr. 1: 50 m M 2011 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinci iterated of Baltimere

5. Social Security Number 6. Sex 7. Age (Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Sex 1**X∑X**M2□F sep. 21, 1938 Hours 213-36-3155 Mary land Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified MD Baltimore Reisterstown 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 320 Academy Ave. 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No 1957-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner 0. Black, White, etc. Completed by 1 Never Married XX Married 1 ☐ Yes XXNo Specify: "natural", Specify: 3 Divorced 4 Divorced White Year or Dates. 1960 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Brewer Beer Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John J. Machlinski Agnes Bew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is, any injury or other traunonce. Dorothy Jane Morris/Wife 320 Academy Ave. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 4 Donation 5 Other (Specify) 2/3/11 Pikesville, MD 21. Signature of Fourer Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Metastatiz Lung Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sepors 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit 4 days Cause (Disease or iinjury that initiated events Ischemic Infanct of the Left temponel lerbe Due to (or as a consequence of): resulting in death) Last Physician/Medical meningitis 3 weeks Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Convincing artery disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Congestive heart Pullure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 2 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 18012 January 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16+ Rupinder Singh, N 11. Date filed (Month, Day, Year) JAN 3 1 2011

DHMH 17 Rev 7/2009

State Registrar

RAYMOND CHARL MACHUNIKI

32. Registrar's Signature

MD Sinci Itagrital of Bultimore 2403 W. Beloculare Ave. Bultimore, MD. 21215

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 9:02 A.M Anthony Leo McDermott January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Sep. 28, 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Year) 1928 Pennsylvania 1XXM 2 □ F Director 176-22-4071 Sep. 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Carroll Hampstead 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zin Code Funeral 3112 Cape Hill Court 21074 America of 12. Was Decedent Ever in U.S Armed Forces? XX Yes 2 \sum No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1949-Black, White, etc. 1 Never Married XX Married ģ Maryland 21215-0036 1956 1 ☐ Yes 🏻 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Hospital 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony James McDermott Mary M. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelley A. Jankowski (Daughter) 3112 Cape Hill Court, Hampstead, Maryland 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jan. 29, 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Manchester, Maryland New Lutheran Cemetery 2011 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Signature of Funeral Sen dicensee 3296 Charmil Drive, Manchester, Maryland 21102 Piter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediz te Cause (Final or condition Physician/ 3 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jlu y that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires Division of Vital Records, 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: DILE 1 Yes 4 Nursing Home 5 Residence မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 27. Morner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury 6 curred injury 5 Pending Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Acrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check nd title of certifie 29b. Signature a 29d. Date signed (Month, Day, Year) W 20(1 2 Name and address of person Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DOROTHY LORRAINE MYERS- MELDROM 11:05 AM JANUARY 2011 Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death SAITIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 KF Days Hours 216,24,1209 MARCH 19, 1928 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **4317 ROSALIE AVE** 21090 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2XXNo 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES GRIFFITH MABEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES KELLY MYERS SON 4931 BROOKWOOD RD. BROOKLYN PARK ,MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY INC 1. 31.2011 BALTIMORE, MD are of Funeral Service Thensee FTNK FUNERAL HOME K. CRECORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1 Enter the disease shock, or hear vailure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC HEMATOMA SUBDURAL disease or condition resulting in death) Due to (or as a consequence of): SE CONDAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnance in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic program
5 ☐ Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca serven in Part I 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 6,00P M FAIL FROM BED 2 Accident investigation JAN 14 2011 1 ☐ Yes 2 ☑ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
SWMMIT PARK REHABILITATION 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Myers-Me Division of Vital Records, Hospital or Attending Physician:

attending physician for use as the buria signed by the us certificate has been s director, page 2 should I 24 hours after deat Funeral Director: filled in by

Physician/Medical

Be Completed by

Certification: To

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State

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Physician

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Physician

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Baltimore, Maryland 21215-0036

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4 ☐ Homicide

(Check only

29a. Certifier

31. Date filed (Month, Day, Year) JAN 3 1 2011

29b. Signature and title of certifier

ATTENDING

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BATI MORE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 27

21225

Rd

1502 Frederick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3455 WILKENS AVE

32. Registrar's Signature Darke

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, G912, 2/14/2011, WS
State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#1perPHYS 12, 2/16/2011, WS

Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
Month 1/25/2011 Mott Curley Moore, **Physician** 10:13 AM 2011 MINUTE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner HOPKINS HOSPITAL BaltImore lonns If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min. 74 1-31-1936 Director 246-54-1185 N.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show rai", or items 23a or 28a-f shore Exactine must be notified at MD Balto 1 XYes 2 □ No Director na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 E. North Avenue 21202 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced 'natural' Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Michels Dist Co. 12th grade Forklift Operator ith and Mental Hygir

27 is marked other

r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Mott C. Moore, Susie Lee Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Irene Toller Moore-Wife 1014 E. North Avenue Balto, MD 21202 Department of Heal Important; If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) King Memorial Pk 2-2-2011 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INOI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 2No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred B Hospital or Attending P 24 hours after death, Funeral Director: After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anuary 26, 2011 ()65 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2000 AMbert Eager St EBMC Michael M.D. 1000 E. 31. Date filed (Month, Day, 32. Registrar's Signature State Back Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	_ State	te of Maryland / Depa Cea	artment of Health . <i>tificate of Death</i>	and Menta	ıl Hygien Reg. N	er in it if	091									
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Dat	e of Death		3. Time of Death									
	Physicia Medic		Nicholas M. Mudrich,	Jr.	/			25, 2011	5:30 P ^M									
	Examin		4a. Facility Name (if not institution, give street an		4b. City, Town, or Location	of Death	4	c. County of Death										
			232 West Bay Front F			Anne Aru												
	Funeral Director		5. Social Security Number 6. Sex 1 🗓 M 2	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date (Mo	e of Birth n <i>th, Day, Year)</i> p • 30 •	1961 9. Birthp Count Mar	lace (S <i>tat</i> e o <i>r Forei</i> gn ry) y1and									
	nd now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10	Od. Inside City Limits									
	arylar la-f s ified	ect	MD Anne Arunde	1	Lothian				1 ☐ Yes 💥 No									
	vith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 232 West Bay Front F	Road	10f. Zip Code 20711		10g. C	Citizen of What Coun United S										
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 If Ye	ed Forces?	Was Decedent of Hispanic Ori if Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify.	n, Puerto Rican, e	or No- etc.)	14. Race - America Black, White, e Specify: W										
5-0	2 hour	Completed	15. Decedent's Education (Specify only highest grade comp	oleted) [(Give	dent's Usual Occupation kind of work done during mos	at of working	16b.	Kind of Business Inc	lustry									
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ary	should be file n and Mental 7 is marked o		19a. Informant's Name/Relationship (Type, Print		ng Address (Street and Numb	er or Rural Route	Number, City	or Town, State, Zip C	ode)									
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Baltimore,	e 1 ar t of He if iter or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remova	ii ii oi ii otate	natory or other place)	Date		Location - City or To										
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cords	law requires that has been signed t ge 2 should be det	Completed			24a.		la. Was an autopsy	Vas an utopsy findings available prior to completion of cause of										
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7	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Examiner: On	the best of my knowledge, death the basis of examination and/or investigation	stigation, in my opinion, death o	occurred at the tim	e, date and pla	ice, and due to the car	use(s) and manner stated.									
ソ	To th withii To th comp		296. Signature and title of certifier	andau !	29c, License number	2752		Date signed (Month, i	-									
	3		30 Nation and address of person Mio complete	d cauce of death (Item 23a) (Type, I	0112,111	WAR	ces	MD 2	21401									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mc Cola Physician/ Stanlei au Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Carroll Lutheran Village If Under 1 Year If Under 24 Hrs. Birthp... Country) MN 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign 1 XM 2 □ F -14-1942 93 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Funeral Director 1 Tes 2 No Carroll Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 21158 Circle 200 st Luke Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify.White than "natural", Completed 3 Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Diagnostic Lab. should be filed within 7 h and Mental Hygiene. 7 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Clinical Biochemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Verne Olschner Micheal Lewis McColgan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4321 45th. St. S. St. Petersburg, FL 33711 Raymond MCColgan/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem, 01.28.11 |Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 8717 Green Pastures Dr. Balto., MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End sta disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death s been signed by the standard should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deplession, Auxiety 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 1 Yes 2 No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 33561 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) Electsburg, my m D 1380 Mogless Way James L. totslew 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25°2011 6:08am [™] Kathryn Joan Musser Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Rossville Baltimore County Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🗆 M 2 🖵 F August 26 1936 Baltimore, Maryland 219 30 7419 74 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1x Yes 2 □ No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 3919 Chesterfield Avenue 21206 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Documentarian Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ည Joseph Charles Hagner Kathryn Kramer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Harford Road Fallston, Md. 21047 Carolyn Wiedeman (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Metro Crematory Inc January 26 2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Chame and Address of Facility

Lassann Funeral Home PA 6 A a <u> 11750 belair Road Kingsville, Maryland 21087</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physicianz disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abundance. burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown for Pregnant at time of death Month Dav Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform No No 1 Yes 25. Was case referred t edical funeral director, Be 26. Place of Death (Check only one) Other: ↑ ☐ Yes a No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work ours after death. leral Director: Ai filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

d State

completed

(Check

and title of certifier

npleted cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 25

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🦪 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LAURIE DAROCA MAHER JAN 2011 6:30 P [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🂢 F Months Days Hours Louisiana Director Yrs 433-70-9660 Oct. Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Herndon Virginia Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3406 Brightfield Court 20171 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 🖟 Yes 2 🗆 No Specify: Specify: Completed 3 Divorced 4 Divorced Spaniard White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Schools should be filed with and Mental Hygier 7 is marked other t <u>Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Juanita Lewis Gabriel Ferdinand Daroca, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a item 27 i 3406 Brightfield Court, Herndon, Christopher M. Maher/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any Injury or ot 1 Burial 2 Ocremation 3 Removal from State Money & King Cremation 1/22/2011 Chantilly, Va. 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Lice Services and Address of Facility Money & King Funeral Home, Inc HUR Vienna, Va.22180 Maple Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ SEPSIS disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day Month Year Pregnant at time of death 5 Other (specify) the g Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an cate has autopsy this certificate Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred After injury Natural Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

MICHAEL BAYDARIAN 31. Date filed (Month, Day, Year,

only one 29b. Signature and title of certific



MC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

USN

29c. License number

01055104A

(IN)

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

20889-5600

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:09 Рм Gordon A. Merritt January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center 6. Sex 1 X M 2 □ F Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. Sept. 26, 1913 Maryland 97 Director 212-07-1272 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tyes 2 No Baltimore MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 2331 Old Court Road 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Divorced 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. General Index Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Co President Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other transment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ida Rose Albaugh Guv Rogers Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2331 Old Court Road #206; Baltimore, MD 21208 wife Frances E. Merritt timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 1/28/2011 4 Donation To Other Specifyent anoment Timonium, MD al Sirv 22. Name and Address of Facility 1050 York Road MD21204 Ruck Towson Funeral Home, Inc. Towson. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of a Immediate Cause (Final cerebral Physician/ Right miadle arteru 5 days disease or condition Medical resulting in death) Due (or as a consequence of): Examiner fibrillation I MONT Sequentially list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Coronary artery disease
Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed month Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Dav 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chronic Kidney disease, hx of CVA, hypertension, 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? hyperlipidemia 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 🗆 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0065809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Towson MD Dimaano, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 31 parked 2011 Registrar

DHMH 17 Rev 7/2009

DE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7205AM Robin W. Michael JENHEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Hours July 16 1955 217-62-8540 55 Director Usual Residence of Decedent or 28a-f show notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, th. Medical Examiner must b. notified at any injury or other traumatic event, the Medical Examiner must b. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8257 Fenton Lane 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. by 1 Never Married 2 X Married 2 🔀 No Yes Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Technician Refrigeration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Genevieve W. Michael Basinger Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8257 Fenton Lane, Pasadena, MD 21122 Deborah L. Michael (spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2011 Baltimore, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility Stallings Funeral Home, P.A. ad, Pasadena, MD 21122 3111 Mountain Road, 23a. Par 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 一个人人为 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence or: Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical トゥルスプロリンプログラン アンファンファンフラン Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 1 🗆 Yes 2 00 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔁 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of WH 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b.c. perFH, G911, 1/31/2011 WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:45 Martha L Meekins 01 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Prince George's Hyattsville St. Thomas More Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1 □ M 2 🛣 F Months Hours Min 1910 579-18-8541 100 MD Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 5811 7th St. NW USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Black Specify: 12 should be filed within 72 nous... aith and Mental Hyglene. A 27 is marked other than "natural" "natural", 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martha Jackson William Bright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 7744 Brink Rd. Laytonsville, MD 20806 Elaine Copeland/Niece other 20b. Place of Disposition (Name of Brookegrove/Steharttown Cem 20a. Method of Disposition 20c. Location - City or Town, State **Gaithersburg** permit. Page 1
Department of
Important: If it
any injury or o ō 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem | 01/27/2011 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Arterioscheretic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown the should be detached To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown NESCENCE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tyes 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 01852 JANUARY 22 2011 hu of person who completed cause of death (Item 23a) (Type, Print) Hyaltsville MD 20781 4203QUEENSSUR DEVORE MIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item II per fh 9912 2-7-11 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 14 / 2011 115pM Physician/ Jack Usher Mowll Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manorcare Health Services Rosedale 8. Date of Birth 9. Birthplace (State or Foreign Country) OH If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-07-2339 ¹XXM 2 □ F 95 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland **Funeral Director** New York New York 1XXYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 250 Pacific St Apt 4 11201 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Argued Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give WW I I 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ģ White 1 Yes XXNo Specify: Baltimore, Maryland 21215-0036 Specify: 3 Widowed W Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Transportation Elementary/Seconday (0-12) Transportation Planner Be 18. Mother's Name (First, Middle, Maiden Surname)
Lula Langner 17. Father's Name (First, Middle, Last) of Health and Mental Hoffeen tem 27 is marked of Item 27 is marked of rother traumatic even Frederick Mowll ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 Pacific St Apt 4 Brooklyn NY 11201 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. Felicia Mowll Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1/17/2011 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilits implicity Crem Thomas Allen PA 7090 Ridge Rd & Fun Serv Hanover MD Signatu e of meral Service License nomy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Demestra disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner areas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical whom Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months?

1 Yes 2 No
9 Unknown Dav Month detached for Pregnant at time of death g | | Ilnknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗆 No 2 1 🗌 Yes certificate Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28b. Time of 27. Manner of Death 28a Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DJIY6Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Snite 30V, BALTIMOREMP N. EUTAW MD

DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neg

31. Date filed (Month, Day, Year

JAN31

86 of Veterans

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 8:05 Tonuary 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death County of Death Maryland linton ince If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State of oreign **Funeral** (Month, Day, Year) 1 🗆 M 2 🔼 F Months Hours **Director** ptember 26 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland 1 ☐ Yes 2 🗷 No Washington neoraes 10e. Street and Number 10f. Zip Code ortant. If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, <u>the Medical Examiner must be n</u> 10g. Citizen of What Country? Funeral Hall 5 Grange Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🗷 No 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Meat Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Ennis Court Fort Washington Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 SChurch Virginia National Memorial 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Service Funeral any Bak obert B South Shirlington Rocal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition resulting in death) -Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed I 23e. Did tobacco use contribute to the cause of death? γ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed this certificate has 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 2 X No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred After Natural injurv 5 Pending work? after death. Accident
Suicide 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 3 the 29b. Signature and title of cept 2 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 2 d ate filed (Month, Day, Year) 32. Registrar 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.